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## Original Articles

### SPORADIC CRETINISM, WITH A REPORT OF THREE CASES IN ONE FAMILY \*

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Ever since the revelations of vivisection have established the relationship of "absence of the thyroid gland" to the cretinoid state, the subject has been one of absorbing interest. There is no more fascinating chapter in the history of medicine than that which deals with the researches leading up to this subject. It combined the efforts of the experimental physiologist, the pathologist, the physician and the surgeon, but to no one class alone does the credit belong for this great triumph of science.

While cases of cretinism are fortunately comparatively rare, the accounts of their improvement and care under proper treatment read like a romance. In 1897, Osler was able to gather 60 cases and since then, through a more widespread knowledge of the disease, many more have been reported. In 1898, McPhedran was able to collect 17 cases in Ontario alone. Sporadic cretinism, as seen in this country, corresponds very closely to the endemic form of the disease seen in the mountainous regions of Switzerland, France, Italy and other countries, the main differences having

been ascribed to the earthy deposits in drinking water and conditions of the soil.

The disease is characterized by changes in the brain, bones, skin and mucous membranes, due to absence of or loss of function of the thyroid gland, causing failure of development and want of nutrition to the nervous system and a strange disproportion between different parts of the body. That these changes are readily recognized makes the diagnosis easy to those prepared to see. There are different degrees of cretinism, varying from the drooling, inane, semibestial creature to the higher grade cretin who is only marked by a slowness in thought and action and a general dulness of comprehension.

The disease may occur at different periods of life. The child may be born a cretin (a rare condition) or more commonly the disease is recognized after the child is six months old, when it begins to show a slowness of development; it lacks the mental brightness of children of its age and, if left untreated, the tongue seems too large for the mouth. The other form is that which supervenes after an acute illness with fever, such as one of the exanthemata. In this form, a

\*These patients were presented before the Wayne County Medical Society in October, 1904.

child apparently well in all of its functions, will be attacked with a fever and rash and then develop the well-known symptoms of cretinism. In typical cases, the child becomes listless and loses the desire to play or take interest in its surroundings. It begins to assume a squatness of figure and the face takes on an expression too old for its years. The nose is depressed between the eyes and the alae are thick and coarse, giving the nose a set back appearance; the eyes seem small, owing to the narrowing of the palpebral fissure, from puffiness of the lids; the ears are thick and heavily formed; the lips coarse and everted, with the tongue lolling from the mouth; the skin is coarse and thick and has a swollen appearance, being usually covered with a dry scale which is rough and harsh to the touch. There is lack of perspiration. There are supraclavicular pads of fat. The abdomen is prominent and gives the spine the appearance of a marked lordosis. The legs are short and the gait slow and waddling. The hands and feet are pudgy, the fingers short and the outline of the joints not well brought out.

If the disease has begun before the appearance of the second dentition, the teeth are ragged and dentition is delayed. The hair is thin and coarse and often comes out in patches. The mental development is equally backward. The child takes no interest in anything but its food, it has no desire to play but rather mopes about. It is slow of comprehension and speaks slowly, with a thick, coarse voice. Memory is deficient and parents will tell you that the child cannot learn at school. No one case will present all of these features nor can a sharp line be drawn between the different grades of cretinism.

While we are ignorant of the nature of the secretion of the thyroid gland and its functions in the human economy, there are certain definite symptoms which arise when the system is deprived of its secretion, and these symptoms correspond very closely to those of cretinism. Again, if the gland becomes atrophied from disease or injury, cretinism follows, the symptoms varying in intensity proportionate to the impairment in function of the gland.

The relation of goiter to cretinism has been carefully studied, but sporadic cretins are much more rarely the subject of goiter than those suffering from the endemic variety. This constitutes one of the main points of difference between the two varieties. Of the sixty cases in this country, reported by Osler, seven had goiter (12%), while of a series, reported by Knapp, of endemic cretinism (60% had goiter. Kocher,\* who has been a thorough student of cretinism, says: "The same influences which lead to goiter are a cause of cretinism. Whenever goiter or cretinism appears in children, one or other of the parents will be found to have goiter."

The more common condition in the sporadic variety is that of complete absence or atrophy of the gland. It is unfortunate that palpation affords so little evidence of the presence or absence of the gland. Cases are reported as not felt, in which the autopsy revealed a gland of considerable size. The pathologic findings of Coulon, Langhans, Hanan and Barker agree, in showing a general degenerative process, shown by the replacing of some of the alveoli of the gland by fibrous tissue and a degeneration of the remaining alveoli.

\**Boston Medical and Surgical Journal*, June 24, 1897.

The cases herewith presented are three sisters, Ida N., aged 21, Libby, aged 11, and Irene, aged 8 years. The parents are Canadians of Scotch and Irish descent. The father, aged 52, is 5 feet 8 inches in height, is perfectly well and has no history of goiter or any hereditary disease. The mother, aged 48, is 5 feet 5 inches in height and gives a history of

and becoming lame, it being necessary for her to go upstairs on hands and feet.

When I first saw her, her height was 4 feet, weight 102 pounds, girth of abdomen 35 inches, waist line immediately below breasts 27 inches, bust measure 32 inches, thigh 18 inches. She has not grown any during the last four years since stopping the treatment, though the



**Plate 1.** Fig. 1. Case one, Ida N., aged 21 years, before treatment.

Fig. 2. Ida N., after 4 months' treatment.

having had a thick neck, when young, and also an abscess in the neck.

#### Case One.

Ida N. (Plate 1, Fig. 1 and 2), aged 21 years, came under my care June 27, 1904. Some four years ago, she was treated with the thyroid extract by Dr. James Samson, for five weeks, but her parents stopped the treatment, because they thought that she was losing her memory

generative system has developed and she menstruated at 20 years. The permanent teeth have all developed, though the enamel is of a poor quality.

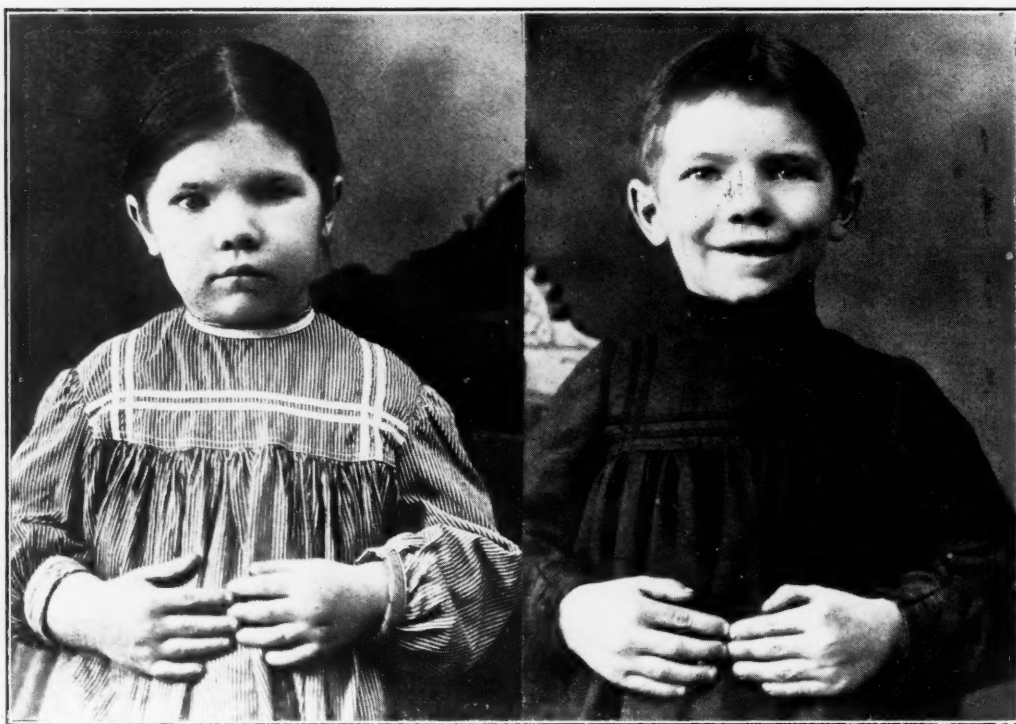
She presents the characteristic signs of cretinism: stunted growth, thick and flattened nose, puffy face and listless expression, pudgy hands and feet, absence of waist line and waddling gait. At the age of 5 years, she had a fever, with a rash, that the mother describes as water blis-

ters as large as the end of the finger. The blisters contained a yellowish serum. After this the child, who had been perfectly well before, became coarse, the hands and feet became stubby and the skin rough. She lost interest in things and steadily acquired the form that the photograph shows. She has been taking Thyroid Extract, grains 5, three times a

over the prospect of growing like other girls. Plate 1, Fig. 2, shows her appearance at this time.

#### Case Two.

Libbie N. (Plate 2, Fig. 1 and 2), aged 11 years, was brought to me by the mother, May 21, 1904, to have something done for the curvature of the spine, which



**Plate 2.** Fig. 1. Case two, Libbie N., aged 11 years, before treatment.  
Fig. 2. Libbie N., after 4 months' treatment.

day, and on September 25, after three months' treatment, has gained  $1\frac{1}{2}$  inches in height, has lost 21 pounds, and the measurements are now: Abdomen, 31 inches; waist, below breasts,  $26\frac{1}{2}$  inches; bust, 29 inches; thigh, 16 inches; height, 4 feet  $1\frac{1}{2}$  inches; weight, 81 pounds.

She now shows an interest in her clothes and wants to pick out a new hat and go out with the rest of the girls. Her gait is smarter and she is much elated

was very marked.

On examination, I found a very prominent abdomen, thighs inclining forward rather than backward, legs very much shortened so that the center of the body was nearer the umbilicus than the pubes. The skin was so harsh and dry that it seemed as if it had been rubbed over with bran. The features were very coarse, the hands thick and without form, and all, combined with the vacant expres-

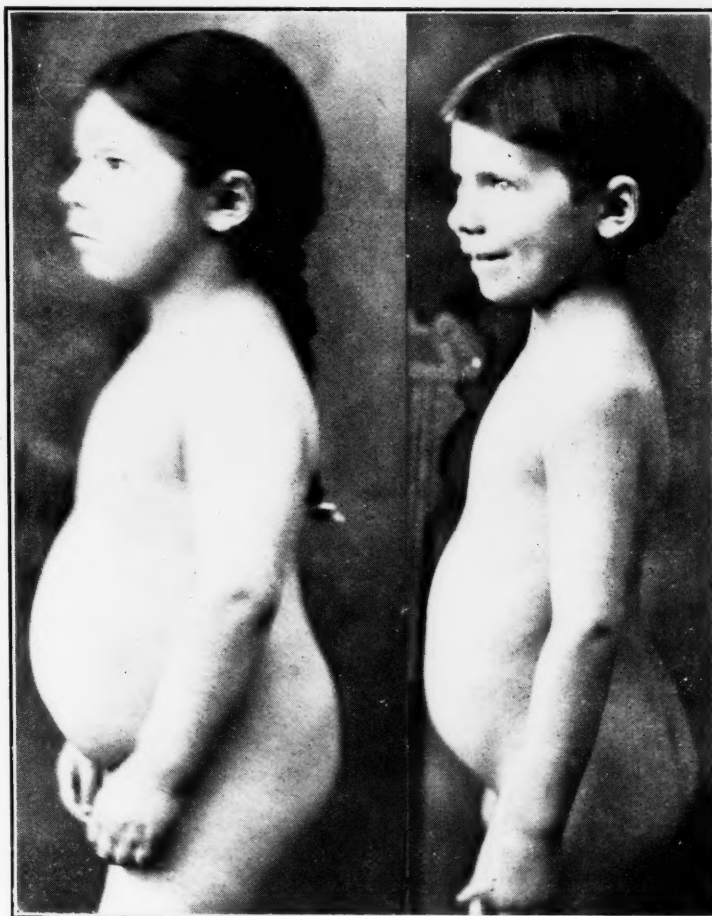


sion and slowness of speech, went to make up the picture of a cretin. I was not able to feel the thyroid gland.

The measurements were: Abdomen,  $21\frac{1}{2}$  inches; height,  $39\frac{1}{2}$  inches; thigh, 16 inches; weight, 49 pounds.

She was put on treatment at once.

caused fever, vomiting and prostration. The abdomen had already lost  $3\frac{1}{2}$  inches in circumference. During the next two weeks the abdomen lessened another inch in circumference; the mother said that the child smiled most of the time and never cried as she did.



**Plate 3.** Figs. 1 and 2. Case two, Libbie N., before and after treatment.

Three weeks after, the mother noticed for the first time that the child perspired. She said the child's temper was better and that she wanted to dance, when her sisters played the piano, while before, she would always tell them to stop the noise. She was then taking  $2\frac{1}{2}$  grains, three times a day, and any increase in dose

Before she began treatment she would rock in a chair all day and the least cross word would make her cry. She never would come to the table unless she was brought, but now came of her own accord. She was then losing her temporary teeth, two central incisors having just come out. Her answers were ready, while before she

would not reply to a question except to merely say yes and no. On September 21, 1904, four months after taking treatment, her condition was as follows: Height, 41½ inches, a gain of two inches; weight, 43 pounds, a loss of six pounds;

tral incisors of the second dentition had appeared.

#### Case Three.

Irene N. Plate 4, Fig. 1 and 2), 8 years of age, came under supervision, June 22,

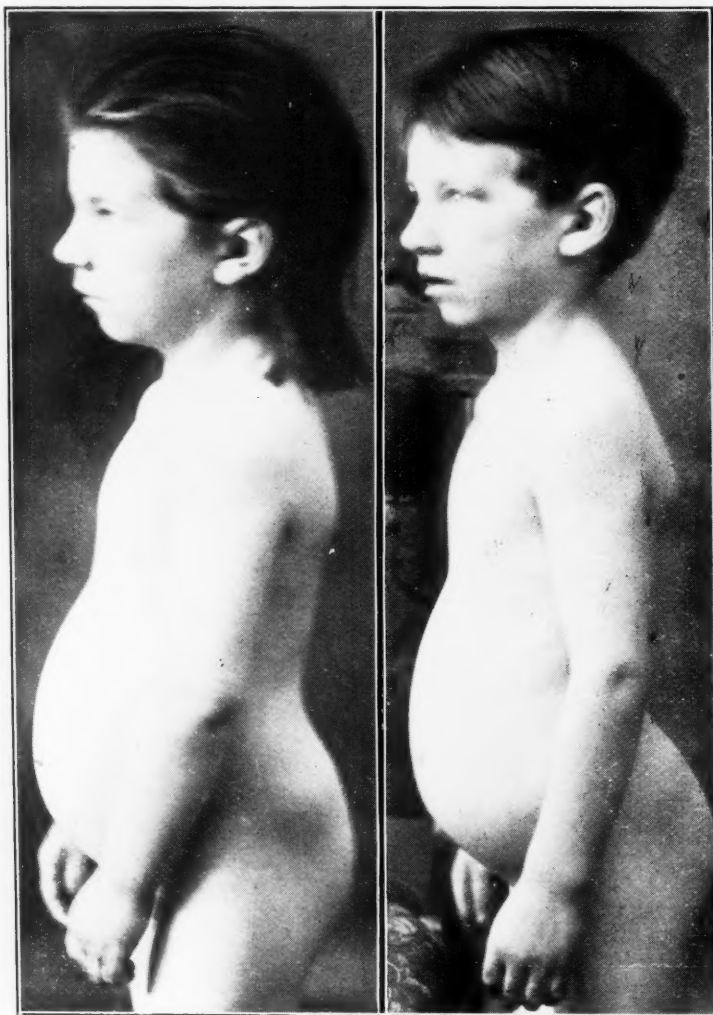


Plate 4. Fig. 1, case three, Irene N., aged 8 years, before treatment  
Fig. 2. Irene N., after 4 months' treatment.

the face was much thinner, the eyes brighter and the figure entirely changed. The changes in the skin and hair were remarkable. Her skin was then as soft as any child's skin. A new crop of hair had come in and it was much more abundant and of a finer texture. The two cen-

1904. Her height was then 39 inches; weight, 43 pounds; abdomen, 23 inches; thigh, 12 inches. The thyroid was not palpable.

The mother stated that until two months ago she had never noticed anything wrong with the child. She was

bright and seemed well. Then the hair fell out in streaks and it seemed as if it would come out altogether; there were some patches perfectly bald; a rash appeared first over the chest, then over all the body and limbs. It started in small blisters, then became large water blisters which broke and left a dry, scaly skin, which, as the mother said, made the child look like a "warty toad." The mother recognized the rash as the same that the

were very prominent. The teeth were decaying but none were loose. The nose was broad and flat at the bridge, forehead low, mouth kept open and expression listless. The hands and feet were stubby and she was slow in all her movements.

Since this case had not been of long standing none of the symptoms were as well marked as in the other sisters.

July 22, 1904. After taking treatment six weeks the patient weighs 39 pounds;



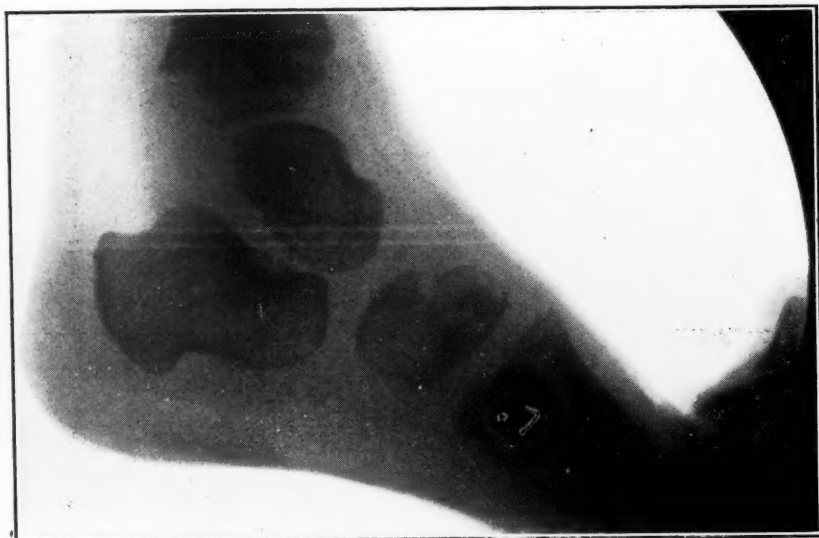
Plate 5. Foot of healthy child aged 11 years.

other two children had had, one of whom has had the rash several times. The mother now noticed the abdomen becoming large and that the child would "poke around" and be listless. Large blue veins showed on the body and the skin became dry and cold and the gait became stiff-legged.

An apparent lordosis was present, the thighs sloping backward, and buttocks

abdomen, 22 inches; the skin is peeling off in scales.

Sept. 21, 1904. After three months treatment, she now shows this condition: Height, 40 $\frac{1}{4}$  inches, a gain of 1 $\frac{1}{4}$  inches; abdomen, 22 inches, 1 inch loss; weight, 38 pounds, loss 5 pounds. The hands and feet are thinner and the outline of the joints can be made out. The skin and hair have improved and the temporary teeth are becoming loose.



**Plate 6.** Foot of Irene N., case three, aged 8 years.



**Plate 7.** Foot of Libbie N., case two, aged 11 years.



The accompanying radiographs taken for me, through the courtesy of Dr. Preston M. Hickey, show very graphically the failure in development in the osseous system. In looking at the foot of a healthy boy of eleven years (Plate 5), it will be seen that the development is well advanced and that even the epiphysis for the posterior tuberosity of the os calcis, which appears at the tenth year, is quite advanced. Comparing it with the feet of cretins, at eight and eleven years,

the exact time the condition developed by the advancement of ossification, e. g.: in the child of eight years the center for the scaphoid, which normally appears in the fourth year, has just made its appearance, while in the eleven-year-old child the center for the scaphoid is not seen, although the centers for the external, middle and internal cuneiform bones are shown. Since the center for the middle cuneiform appears in the early part of the fourth year, we would infer that the



Plate 8. Hand of healthy child, aged 11 years.

the difference will be seen to be well marked. (Plate 6 and 7). It will also be seen that very little change has taken place in the bones from the eighth to the eleventh year; if anything, the foot of the eight-year-old child is further developed than that of the child aged eleven. This was possibly due to the fact that the disease appeared later in one than in the other, after which no osseous development took place. We can judge almost

disease overtook the child at the latter part of the fourth year. The study of the development of the carpus yields a similar inference.

Now, since the fever and rash described by the mother came on at a later period, it would seem that these symptoms came on after the disease had been established and was not, as the mother supposed, a causative factor. It is reasonable to suppose that the "fever" spoken of was one

of the common infections, perhaps one of the exanthemata, but so modified by the already diseased condition of the subject that it was not recognized.

When we consider the extraordinary influence of the excessive secretion of the thyroid gland over the different parts of the body, as portrayed in the condition known as hyperthyrea and the opposite condition, athyrea, or absence of secretion, we realize the very great importance

In the absence of accurate information regarding the character of the acute illness, we are unable to be positive as to its nature, and there are no apparent influences arising from the drinking water, the soil or the sanitary surroundings that would have any bearing on the condition.

When the pathology of cretinism was understood, it was not a great step to suggest a treatment and herein lies ample reward for all the research spent upon



Plate 9. Hand of Irene N., case three, aged 8 years.

of the thyroid function in the economy of the body.

The rapid pulse, moist skin, vasomotor instability and nervousness of the one, contrast markedly with the sluggish vascular system, dry skin and apathetic nature of the other. It would seem that a nice balance is maintained in the normal organism, which when disturbed one way or the other, gives the characteristic symptoms of each.

the subject. It is no simple achievement to redeem these unfortunate victims from hopeless idiocy, from objects of pity to those around them and an affliction to their parents, to a place of usefulness among their fellows, to transform them into rational, thinking beings from the low animal plane where nature doomed them to be. The results of treatment do not fall short of the marvelous.

It does not seem to make much differ-

ence in which form the thyroid substance is supplied to the system, for the results are the same. The most convenient way is by feeding the desiccated gland. The administration must be begun slowly until the system gets accustomed to it, as overdoses cause fever, rapid pulse, headache and depression. It is well to begin with one grain three times a day and gradually increase to five grains, three times a day, as it is borne. Within

and velvety, and the coarse dry hair is replaced by a new crop of thicker and finer hair. Dentition proceeds at once from the stage at which it has been arrested. The stature increases remarkably and is one of the most constant evidences of improvement. It seems as if a weight has been suddenly lifted off the unfortunate victim and he assumes a new attitude toward life, in his play and in everything around him. When all evidences of the



Plate 10. Hand of Libbie N., case two, aged 11 years.

a month or six weeks, improvement is noticed and the change steadily progresses. The weight is reduced, the child becomes more shapely, the face becomes thinner, puffiness disappears, and the eyes appear brighter. The prominent abdomen and supraclavicular pads become smaller. A marked change takes place in the skin, it loses its pallor and roughness, the scales fall off until it becomes soft

disease have disappeared, the treatment may be left off for a time and some patients remain well, while in others, symptoms of relapse show that the treatment must be carried on at intervals.

## WHY NOT BE FRANK WITH THE PUBLIC?

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Marquette.

Much is being said nowadays concerning the relation of the public to the medical profession, and concerning the secret of power in Christian science and kindred delusions. There is one aspect of this question to which I have not seen reference. It long ago occurred to me that the medical profession had itself to blame, that the laity is attracted to these various forms of suggestive therapy, as something new and of mysterious power.

The profession has not been candid with the public. Doctors know that a vast deal of medical treatment which is asked of them, and which they give for a consideration, is needless; this applies not so much to the surgeon and diagnostician, as to the general practitioner. To him comes the host of the vaguely suffering, the people who do not know how to live, and resent instructions, the functionally disturbed, and the neurotics. Experience and tradition have led them to expect medication from the "medical man"; they get it; it fails, and they drift, perhaps bringing up at a Christian scientist's or a magnetic healer's. Persuaded by them to ignore sensations, their shackles fall off, and they discover that "they never needed medicine at all." Then one of three inferences is inevitable, either the doctors knew that the patients did not need drugs, in which case it was a fraud to prescribe and receive money from them, or they did not know it and were ignoramuses, or the special form of suggestion by which the patient has found relief is a great and precious discovery, a revelation outside the ken of a bigoted "medical profession."

Now, had the physicians been able to make out the character of these cases and been absolutely candid with the patients, had they refrained from medication, even by placebos, and frankly explained the nature of the trouble, and had they urged the patient to forget and look out and not in, at least the profession would not stand humiliated, as it does in the eyes of so many, at the present day.

In the face of the good they are doing, it is quite useless to call these various types of auto-suggestions "delusions," for a host of witnesses will rise up and say, "while once we were invalids when taking drugs, now we are well, since we rejected all medicines." To explain the benefit obtained, as suggestion, does not rescue us from the position of having for years needlessly dosed these patients,—neurotic, hypochondriac, hysterical, call them what you like, for all they really needed was to be taught self-forgetfulness.

Our profession has been wallowing in a slough of excessive drug giving these many years; a strange and seemingly instructive wisdom has actuated the popular rebellion against canonical therapeutics. Hahnemann led one form, "Homeopathy"; the public and the medical profession as well, learned not only that nauseous doses and indiscriminate bleeding and purging were needless, but even injurious, and perhaps homicidal, and also that many ailments subsided of themselves under the care of the little-pill men and their water-drops. That movement was a great revelation to us, but did not go far enough, and to-day



the Christian scientist is "telling our public "that not even little pills and water are necessary, but that faith or prayer, or mental attitude suffices."

Hahnemann surprised the doctors as much as the laity. The results of Christian science do not surprise the physicians of to-day at all; they knew all about auto-suggestion before; indeed, the educated physician is prepared to go much farther than "Christian science," for if he spoke fully and candidly, he would say "you need neither drugs nor water drops, nor prayer, all you need is to disregard sensations, live right and forget yourselves." Why, then, does he not do so?

One reason and usually the first that would be advanced in justification, has been, "that unless we satisfy the patient's craving for medicine, even though not clearly indicated, he would seek advice elsewhere, and wander to some less discerning, or less conscientious rival." If reasons were made public, it might remind an unsympathetic laity of the ancient robber's plea, "that the traveler is sure to be fleeced farther on, and may as well give over first as last." Others say, in effect, that "the interest of the patient demands that he have a skilled physician; if dissatisfied with myself, the skilled physician (the major premise), he may pass to the care of the unskilled and unscrupulous; then if he fall really ill, he will suffer for his folly; better for his own sake, therefore, that I retain my hold upon him, so that I may be there to help him when he really needs aid." Probably few put the matter thus jesuitically, yet in one form or another, I fancy this argument affects many minds that would spurn the idea of doing wrong.

Most men state the case in this way: "We are not doing wrong; the patient

comes voluntarily into our hands; we cannot without giving offense be candid with him or her, especially her; for the one thing the public will not stand is candor about their ailments. We must take these cases at their own valuation, administer medicine or placebos as our judgment guides, and if we fail, we have done the best we could under the circumstances."

The point I am raising is, of course, *whether this plan is the best?* No one rejoices more keenly than the writer in the advances all along the line of our great calling; no one sees more clearly the public danger of extending systems of auto suggestion to ills, other than the vaguely nervous, or functional disorder, or agrees more heartily to the necessity of requiring all practitioners of healing, under whatever guise, to give proof of knowledge, lest faith cure be applied to diphtheria, for instance; yet the result obtained by systems of self persuasion, so ingeniously adapted to the needs of the weak-kneed and unstable, may well cause us to examine our own methods carefully. We should let no casuistry or veiled self-interest mislead us into virtual dishonesty, but we should meet the public candidly and openly. This is the best means of silencing invidious comment upon medicine, as it is practiced by a small number of the less honorable and skillful of our profession. The physician can have no better guide in professional life, or higher precepts than those which the much maligned code presents.

The profession is looked to as the conservator of medical morals. Its code of ethics is not more advantageous to the physician than to the public. In the majority of cases, it is the violator of the code, who violates the code of gentle-

manly and honorable conduct; its best provisions guard the patient, the family and the public. No more exalted rule is found, outside the teachings of the Great Physician, than its precepts afford.

Finally, the laity is interested in the

development and triumph of science. Each of us will find an abundant opportunity to influence public opinion in support of scientific medicine, preventive or curative, and in so doing to advance civilization and the interest of humanity.

## THE OPERATIVE TREATMENT OF RECENT CLOSED FRACTURES.\*

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Detroit.

The art of surgery has seen greater progress in almost every other department than in that of fractures. The abdomen, cranium and thorax have experienced wonderful inroads and their emergency, plastic and regenerative surgery have all been placed on a recognized basis, even in the eyes of the laity. The surgeon operates to suture the ruptured liver, spleen, or kidney, the ruptured uterus, tube, or intestine, and his results are brilliant. But the broken bone is still treated in the dark, figuratively speaking. Many testimonials to the inadequacy of ordinary methods are visible daily in the shape of shortened thighs, crooked legs, stiff elbows, gunstock arms and other deformities. The uncertainty of results causes these injuries to be the bugbear of the physician and even the most experienced men have by no means uniform success.

Reflections of this nature prompted an investigation of the subject of operative treatment. It is, of course, not new. For over twenty years, Mr. W. Arbuthnot Lane, of London, has assiduously practised and expounded it. But the literature is scanty and old methods still predominate. French, English and Ameri-

can references are occasionally found, but German less often; and if we exclude the patella, the paucity is more striking. Bold as surgeons have been, their boldness for some reason has not endured in this field, except in occasional instances. What is the reason?

It is mostly fear of sepsis. It is argued that a broken bone will usually heal sooner or later, if assisted according to established customs. The spiral fracture of the tibia will ultimately mend and give the patient a leg to bear weight upon, even if it is short and perhaps a little *vagus* or *varus*. The anatomical and functional defects, following many fractures, are often far greater sources of pain, inconvenience, disability or mortification to the victim than a hernia, a retroverted uterus, or a varicocele, than a hypertrophied rectal valve, a cystic ovary, or an adenoid. Yet an operation for any one of these conditions may have as disastrous sequelae as a fracture operation. The fear of sepsis is valid, but it has not in the past deterred men from more serious surgery, not to say less advisable.

There are, it must be admitted, eminent

\*Read before the Wayne County Medical Society, January 22, 1906.

authorities who urge conservatism. For example, Beck says: "While under the auspices of asepsis such treatment need not be followed by any reaction, and might in the hands of competent masters, give excellent results in suitable cases, such tendencies must be regarded as surgical aberrations. It is only where much diastasis is present, as in fracture of the patella and olecranon, when bony union appears improbable, that such rigorous interference is demanded." Again Stimson takes a similar stand, though in his last edition he gives more space to operative measures than in previous issues. Scudder is less opposed, and alludes to open fixation more favorably, as do Pilcher and Keyes. Lane, on the other hand, is radical in espousing operation. "I would insist that in every simple fracture in which it is important to the individual that the original form of his skeleton shall be retained and his mechanics suffer no alteration, the surgeon should, *failing to obtain accurate apposition, as determined by the radiograph*, cut down on the seat of fracture, and restore the bone or bones to their original form. He must not be satisfied with what is clinically called 'good position,' when by operation, he can obtain a perfect result, and in the case of the leg this is particularly important. \* \* \* \* \* I cannot help feeling that a clearer perception of the mechanical conditions which are present in fractures will influence surgeons very materially in favor of operative measures and that the treatment of fractures will be based on scientific principles and will soon cease to be a disgrace to surgery."

Golding-Bird is equally partisan in this view, and after years of practice these men are no less enthusiastic. Little by little the principle has extended until

there is hardly a fracture that has not had primary suture, nor a surgeon who has not tried it, while suture of the patella is almost a routine measure. This is not to say that primary open fixation is common, at least in this country, for it is not. The practice thus far has been mostly tentative.

One great factor in the slow development of bone surgery has been the tardy understanding of bone pathology. The tissue changes accompanying fractures were not well known until operations for compound and ununited fractures were frequently performed. It then became evident that it was far more common than supposed, for fascia, muscle, ligament, nerve, or blood vessel to be interposed between the fragments; that non-union and pseudarthrosis were usually due to such interposition; that "exuberant callus" sometimes meant faulty apposition; that nerves, vessels, and other structures were frequently injured or destroyed by these accidents; that extensive hemorrhage occurred oftener than suspected. These findings show that we do not know what condition may exist in any given fracture; they also show that these factors, which so seriously militate against good results, can be exactly diagnosed and accurately remedied by operation.

A further light upon fractures has been afforded by the Roentgen ray. No injury involving bone should be treated without a skiagraph, and no reposition should be trusted without the same test. This applies equally to operated cases.

A few years since, Scudder compiled the results, three to five years after injury, in a series of leg fractures treated conservatively; 60 to 81% showed poor results. What would be the comment on

an equal percentage of poor results in the non-operative treatment, for instance, of appendicitis? In conservative handling of fractures only one thing is certain—and that is the *uncertainty* of the outcome. Open treatment can do no worse.

To take up fractures in order. Everyone recognizes without question the necessity for operation in certain fractures of the cranium; when there are grave symptoms from hemorrhage, or depression of bone, one is in duty bound to operate. Fracture of the spine is regarded similarly, though results are discouraging and many men still advocate the expectant policy. It is, however, to other fractures that I wish particularly to draw attention. Few fractures have exercised the ingenuity of surgeons so much as that of the lower jaw. The variety of devices is legion, each having a limited success in the hands of its originator. But the direct fixation of the fragments has been comparatively little tried, being mostly regarded as a last resort when other means have failed. McCurdy, of New York, however, prefers it as a routine method of primary procedure, and reports good success. Carter, Vernet, Péraire and Mahé, have also advocated it and contributed to the literature. The method is simple and effective, but it would appear that it ought to be limited to selected cases that are not amenable to non-operative means.

Fractured upper jaws and malar bones are not often encountered, nor is there usually any active surgery practised for them. But they are quite sure to leave an altered physiognomy and this can be averted by a simple method. When the malar eminence is indented, the fragments can be raised through an external incision, or one in the mouth, at the

junction of the upper buccal and alveolar mucous membrane. This avoids a visible scar, but abscess has been known to occur. Lothrop, in a recent paper, describes a variation of the method and reports successful cases. He elevates the depressed portion of the malar, together with the superior maxilla, if affected, by instruments passed through a small opening in the mandible fossa. The antrum is packed, if found necessary in order to keep the position good. He has met with no sepsis and the results were very satisfactory. Precautions must be taken in advance to get the mouth clean, and after operation great care in the manner of administering food.

Fracture of the clavicle is fairly sure to unite—and likewise fairly sure to leave some deformity. But this is rarely visible nor does it cause functional inefficiency. If there is comminution, suture may be required, or if a fragment embarrasses the respiratory apparatus, the large vessels, or the brachial plexus, as in a case reported by DeRouville. Fractured clavicle is of itself such an unimportant injury that it will seldom need primary open fixation. Case reports are not wanting, to be sure, and in event of both clavicles being broken, Pluyette says suture is demanded if there is any dyspnea.

The sternum is very rarely broken. If there is depression of one or both portions, it may prove serious and when manipulation fails, operation should be done. The fragments can be directly pried into place or the bone may have to be trephined to get a proper purchase.

At the shoulder, we meet an injury which yields only to open treatment as a rule. There can be few but will appreciate the futility of treating a fracture of the neck of the humerus, associated with



dislocation of the head, by any other than operative means. Manipulation is seldom successful. Open incision, reduction of the head, bone suture if possible, or resection of the head if necessary, is the rational treatment. The hooks devised by McBurney are useful in the operation. If this injury is untreated, a practically useless shoulder results. But by operation perfect function is sometimes obtained and at least a useful arm. Fracture-dislocations of the shoulder should be referred to a surgeon as soon as the diagnosis is made. Besides the regular text-book references, articles have been written by Brigham, McBurney, Allison and Jones, Benjamin, and Curtis, with details of cases. Some of them are secondary operations, because the condition was not originally correctly diagnosed. These also gave brilliant results.

Uncomplicated fractures of the humeral shaft can usually be held in good position. But a certain proportion of oblique or comminuted fractures ought to have open fixation promptly, if good result is desired. It is in just such fractures of long bones that this treatment is neglected, and where it is capable of doing the greatest good. At the lower end of the humerus again we find a fracture that is prolific of bad results, i. e., the supra-condylar fracture, and also the separation of the epiphysis. It is difficult to keep proper position, and if it cannot be done, operation should be at once advised, with the assurance of much better chances for recovery. This stand has been taken by Santi, Gaudier, Lane, Shands and Roberts.

The olecranon occupies a position similar to the patella, both in its anatomical and functional relations and in its fracture-pathology. The fragments are likely

to separate widely, and bony union is uncertain, but in spite of this fact the elbow proves useful, in the majority of cases. Yet Beck, who calls open fixation a "surgical aberration," makes an exception of the olecranon. It is true that suture assures firm union and shortens convalescence, and is frequently practiced. The subject has been discussed by Pouly, Berger, Tancrazi, Coste, Abadie, and Moore, and all the text-books dignify it with more or less mention.

As for fractures of the fore-arm, open suture is seldom performed, except as a late measure, after delayed union or malunion. Occasional poor results of this kind suggest that conservative treatment is inefficient. It is the knowledge of fracture pathology that will enable one to choose such cases for early operation. If the skiagraph shows comminution or approximation of the two bones, or if there is serious impairment of the soft parts, the open method is indicated.

Coming now to the lower extremity, there are to consider, more fractures that indicate open fixation than in any other region. This is mostly due to the fact that bad results in the lower extremity produce great deformity and disability, and that it is harder to secure perfect apposition, as the muscles are powerful and the displacement in proportion. As Lane says, leg fractures materially diminish a man's earning capacity, especially among certain classes, and in these cases it is highly important to obtain a functional result as perfect as possible.

The open fixation of the neck of the femur has been done by many men, and written upon by Loretta, Ito and Asahara, Davis, Allison and Jones, Freeman, Painter and Koenig. The last named asserts that operation should not be delayed

beyond eight days, else it will prove very difficult. The usual retaining agent is the screw or nail. The adoption of this method is not likely soon to become universal, because any operation around the hip is difficult and not devoid of danger. Moreover the majority of these fractures occur in old people, on whom such an operation is of doubtful advisability. Nevertheless Lane declares that "in old people an operation is often more imperatively called for than in vigorous life, for the reason that prolonged recumbency in old age is a very serious matter, often entailing, of necessity, a fatal result. The shock sustained because of surgical intervention is trivial, and old people bear operations very well indeed." In children at any rate the operation may occasionally be advisable, because in their case, bad results become increasingly bad, causing coxa vara and shortening.

Fracture of the shaft of the femur is another fertile source of ugly deformity and altered gait. The tendency to shorten is hard to combat, the extension apparatus is tedious, and ambulatory treatment has not yet met with common approval. Delayed union or absolute failure of union is most frequently exemplified in the femur, and no other bone exacts such heavy penalty in months of waiting and discouragement. And when finally late operation is done, it is usually found that interposed tissues have been the obstacle. There ought to be no hesitancy in suturing these cases primarily, if there is any difficulty in maintaining apposition, or any comminution, or suspicion of soft tissues between the fragments, or other complication. If these indications were obeyed it is likely that a large portion of the fractured femurs would be operated, and that results would be greatly improv-

ed. Exactly the same remarks apply to the tibia, whose spiral fractures especially are very hard to treat by retentive means. Descriptions of operations and results in these cases have been given by Thiery, Bossuet, Guibal, Jopson, and Lane.

Fracture of the patella is one of the exceptions made by the opponents of open fixation. This seems to me a singular inconsistency, especially as they urge sepsis as a chief objection. If I were to choose from the whole skeleton a fracture in which sepsis were most undesirable it would be the patella. The luckiest outcome of a septic knee-joint is ankylosis, amputation is frequently necessary, and death has occurred. Moreover the conservative treatment is fairly efficient and useful legs commonly follow it. This merely emphasizes the remote possibility of infection and the confidence of modern surgery. It is of itself a strong argument for the wider extension of the principle. In 1898, Powers studied 711 operated cases and found 10 deaths, 3 of these from sepsis, i. e. 1.4%. This per cent would doubtless be bettered in a record of the last seven years.

The literature of fractured patella is extensive. In a recent number of the *Lancet*, Moullin reports 40 cases of his own treated by operation. Quinby reports the end results of 30 cases. Of unoperated fractures the outcome was perfect in 50% and poor in 33%. Of operated cases, the outcome was perfect in 65% and poor in 15%. The per cent of fair results was about the same in both. Although many men operate nearly all cases, certain authorities advise against indiscriminate interference. The prevailing opinions are well expressed by Scudder, saying: "Whether operation shall be done or not depends upon the degree of

safety with which it can be performed. It is the surest method of securing bony union. It should be undertaken only by surgeons of exceptional judgment and great skill, who have at command skilled assistants, and who can work under the most rigid aseptic conditions. The acute symptoms should be allowed to subside before operation. The operative treatment should be confined to healthy individuals under 60 years of age; to fractures with a distinct separation of the bony fragments and extensive lateral fascial tears; to cases presenting great joint distention that does not disappear quickly. It should be seriously considered, if the individual's occupation is arduous and necessitates much standing or walking. The patient should be informed as to the probable outcome by the two methods of treatment. The danger to life and limb should be fairly stated." Martin and Thomas state that the results of conservative treatment are in no way comparable to those obtained by operative means.

The foregoing is a list of fractures that have been subjected to operation. It is not complete, but it includes the most important. The others comprise isolated cases, done for complications so unusual as to be hardly more than curiosities.

It is evident that open fixation ensures good results in properly selected cases, but it would be extreme to recommend its use indiscriminately. In discussing the above special fractures, I have dwelt on the indications in each instance. Certain general indications may be deduced from these, and they are divisible into two classes—1st, those of convenience, and 2nd, those of necessity. By necessity, I mean that life is endangered by conservative methods. Under this head are in-

cluded fractures of the cranium or spine, producing grave symptoms of the central nervous system, and fracture of any bone which impinges upon large nerve trunks, important vessels, or vital organs. Among such are reported fracture of the rib, piercing the pericardium; of the pelvis, perforating the bladder; of the clavicle, rupturing the axillary vein or pressing on the brachial plexus; of the femur, rupturing the femoral artery. Such complications offer no choice of treatment. Other operations will be merely of convenience, i. e., the patient will live and not be seriously maimed by the adoption of ordinary means of treatment. Operation will be considered with the idea of either cosmetic, anatomical, or functional improvement. It will not be undertaken in aged subjects, or those suffering from disease which contra-indicates anesthesia or operative shock. Certain bone lesions would prevent suture, such as syphilitic osteitis, or osteomyelitis. If none of these conditions exist, the positive indications are as follows: (1) inability to hold the fragments reduced; (2) fractures near or implicating joints; (3) fractures which for any other reason threaten deformity or poor function; (4) comminution; (5) fractures of a limb upon whose integrity depends the livelihood of the patient.

Between the two classes of indications that I have mentioned—convenience and necessity—there will always be a wide divergence. Medical men agree, with much unanimity, upon imperative surgery, the abdominal emergency, the cerebral injury, grave hemorrhage—these are usually treated by active surgery. But operations that are not demanded as life-saving measures are not so uniformly approved. Yet this hesitancy, among both physicians and the laity, has been over-

come in so many instances that it seems as if it must be only a matter of time when fractures will be more extensively fixed by the open method.

The disadvantages of operative treatment are: (1) the danger of attending anesthesia; (2) risk of sepsis; (3) possibility of necrosis; (4) presence of a scar; (5) the possibility of not being able to hold the fragments after open treatment; (6) the necessity of removing metal appliances at a later date. As to anesthesia, it is customary in the conservative treatment of fractures and therefore cannot be reckoned as a risk greater in one method than in the other. As to sepsis, the risk is greatest in suture of the patella, yet that is the one instance most generally recognized. Sepsis cannot therefore consistently be urged against other bone fixations. The chances of necrosis are probably very slight, except with sepsis. It occasionally occurs when metallic, foreign bodies are left for a long time in the bone. As a matter of fact, they should not be allowed to remain after serving their purpose. The presence of a skin scar is a small factor in these days, and especially when it exists in inconspicuous places, where these scars usually are. The occasional failure of the various agents hitherto tried to hold fragments in place is an admission of weakness on the part of those who make the complaint; no failure has ever balked the abdominal surgeon; the worthlessness of one method of doing intestinal anastomosis has only stimulated effort to find a better, and not to condemn the principle. The poor technic and results of the early gastro-enterostomies have given rise to increased labor in perfecting better means. The failure of all methods of nephropexy in curing certain symptoms does not deter men from

still elaborating new methods. A few failures then in bone suture may be only because we do not as yet know how, and not because the principle is wrong. With larger experience the details will improve, making towards better results. Arbuthnot Lane's success attests the value of the principle.

The advantages in open fixation are plain: (1) Exact conditions of bone and soft parts are ascertained and remedied. (2) The need of repeated manipulation, which often happens in conservative treatment, is obviated. (3) Convalescence is hastened. (4) Non-union, mal-union, and pseud-arthritis are much less likely to occur, and the ultimate result is much more certain to be good.

A brief mention of technique and appliances will complete this subject. Of all the materials used in the open fixation of fractures, silver wire is the mainstay. By various ways of applying it, wire may be made to serve nearly all the other devices, or it may be used in conjunction with them. Nails, screws, pegs, pins, plates, ferrules, clamps and staples, made from different metals, bone, ivory and celluloid—all these are used, and associated with some of them are the names of their inventors. There are the staples of Jacoël, the Parkhill clamps, the Halsted plate, the Steinbach and the Agnew plates. The ideal way, of course, is to use absorbable suture material, and it can be made to serve in many cases, but more often it is insufficient in view of the great strain it is obliged to undergo. In nearly all recent fractures of the patella, catgut is the material of choice, applied according to the method of Blake or Stimson. Metal wire sooner or later usually causes trouble, and I have twice removed it from the patellae on account of suppuration.



though the operation was done years previously. Those who make a practice of employing non-absorbable appliances advise removal as soon as the bone is united and the wound firmly healed.

It hardly needs to be added that absolute asepsis is the keynote of success in these operations. Lane advises that not even a gloved finger be put in the wound; all the tissues should be handled with instruments and the longer the handles the better. Skin edges ought to be covered as soon as the incision is made. In short, he urges the extremest measures to at-

tain asepsis.

In conclusion, it is fair to assert that the open fixation of fractures has not been everywhere honored with a sufficient trial; that the advantages to be gained make it worthy of serious consideration; that there are certain well-defined indications for undertaking operation; that absorbable suture should be used whenever possible; that the long bones are especially amenable to open suture; and that physicians should advise its employment where there are indications as enumerated above.

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## DISCUSSION.

Dr. Max Ballin said that it once would have been considered a crime to make an open out of a closed fracture, on account of the great liability to sepsis due to the laceration and devitalization of the part. This liability is as great as ever and contraindicates operative interference with closed fractures except when accompanied by the more perfect asepsis of modern times. With the most perfect asepsis possible, however, certain closed fractures should be opened, as fracture-

dislocation of the head of the humerus, certain cases of fracture of the femoral neck, fractures of the patella. To illustrate the danger of septic operating in these cases, Dr. Ballin mentioned the results of three recent operations for fractured patella that had been brought to his attention: one amputation, one case as good as amputated, and the third case with a stiff knee.

Dr. W. H. Hutchins said that, unless contra-indicated, operation in closed fractures was made

advisable by any of the following factors: strong distracting muscle pull, as on the patella, olecranon, or os calcis; severe comminution; harmful pressure by bone fragments, as on nerves, or blood vessels; involvement of joints. Immediate operation should be performed on fractures of the spine, inferior maxilla, and patella. In about 25 operations for fractured patella, coming under his care, there was only one instance of considerable impairment of joint mobility. Uses non-chromicized kangaroo tendon.

Dr. H. O. Walker: A general anaesthetic should be the rule in introducing treatment of every fracture. In failure of apposition, operate. Massage very early; in some cases, immediately. Dr. Walker exhibited a long screw which he had used to hold in apposition the fragments of an oblique, otherwise unmanageable fracture of the lower part of the femur. Under ordinary treatment, this fracture had begun to unite with great deformity. The screw was left protruding, and later removed.

Dr. P. M. Hickey: Of many non-operative results of fracture, I have seen only one radiographically perfect. Radiography shows that manual diagnosis of the position of the broken ends is liable to great error.

Dr. T. A. McGraw: Results radiographically imperfect may be clinically satisfactory. The patella is readily accessible to instrumentation; op-

eration on this part, therefore, is less liable to septic contamination than operation on the middle or upper part of the femur, where manipulation and bruising of the tissues are unavoidably greater and more prolonged.

Dr. H. C. Wyman said that for 18 years he had been operating on fracture of the hip, without reason for regret. In treatment of fracture of the patella, it is important not to obstruct in any way the circulation of the part.

Dr. Oakman: The object of the paper was to point out the indications for operation in certain fracture cases. The knee joint, while credibly less liable to be infected in operation than less accessible regions, is a most dangerous place for sepsis. Theoretically, surgery can never be completely aseptic, and asepsis is a relative term; but preventable lapses from asepsis occur in surgery of the abdomen, without being recognized or without being recognized as such, because the abdomen, better than certain fractured bones or joints, can cope with, or conceal, slight infection. Strict insistence on approved modern means and unremitting watchfulness prevent these lapses, and produce practically asepsis. With asepsis of this order, immediate operation on certain closed fractures will save certain patients from prolonged convalescence, and from chronic pain, disability, and deformity.

## THE TREATMENT OF CHRONIC CONSTIPATION WITHOUT CATHARTICS \*

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Constipation may be defined as the voiding of insufficient amounts or abnormally prolonged retention of fecal material in the intestinal canal. Constipation, in contradistinction to obstipation, is due purely to functional conditions or diseases of some portion of the intestinal tract. Obstipation, on the other hand, is a condition in which there is a sufficient quantity of fecal material and a normal functional activity, but in which some deformity, growth, flexion, constrict-

ture or foreign body in the intestinal tract offers a mechanical obstruction to the passage of the fecal current. These two conditions are so frequently confounded in the mind of the average practitioner that the distinction must be always borne in mind, for the treatment of these conditions, while they may present similar symptoms, is entirely different.

Constipation is really but a relative

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condition. One individual may have two or three passages daily and still be constipated, while another individual may have but one passage a week and not be constipated.

Constipation in itself is not a disease but merely a symptom of a great many diseased conditions. It is not my intention to-night to take up the treatment of acute constipation or the treatment of either acute or chronic obstipation, as the subject is too large to cover in a short paper. In fact, the treatment of chronic constipation alone can scarcely be satisfactorily touched upon in a twenty-minute paper.

Obstipation is caused by such mechanical conditions as malformations of the intestinal canal; stricture; adhesions; pressure from the pregnant uterus and the various abdominal tumors; angulation; enteroptosis; appendicitis; cecal ptosis; stenosis of the ileo-cecal valve; fecal impactions; foreign bodies; hypertrophied rectal valves; prolapsus; large hemorrhoids; large prostate and hypertrophied sphincters.

Chronic constipation is a condition which affects a large proportion of all the patients treated by every practitioner of medicine. It is a condition which affects a great many practitioners themselves. It is a condition which is brought about by our modern, so-called strenuous, life. We find it in the infant and in the nonengorged. It is due to a great many factors, and in order that you may understand it more fully, I will digress a moment and review a few points in the physiology of peristalsis and defecation. One may say that up to the last moment at which the fecal mass is expelled from the anus, the ingested materials are carried through the intestinal tract by what is known as

peristaltic action. After the food has entered the stomach and the albuminoids converted into peptones, it passes through the pylorus into the small intestine. As the stomach contents pass through the pylorus they are acid. The secretions in the small bowel, the bile and the pancreatic juice being alkaline; when the acid stomach contents are poured into the small intestine, coming in contact with the alkaline intestinal secretions, a stimulation or irritation is caused, which produces a wave of muscular contraction or peristalsis. At the same time that the chemical reaction of the acid stomach contents upon the alkaline contents of the intestine is going on, certain gases are created. These gases serve to distend the calibre of the gut and by their distension still further stimulate muscular contraction. These gases are not abnormal but serve a most useful purpose. It is when they are in too great quantities and too severe peristalsis and consequent great distension of the intestinal canal ensue that they are harmful; they then cause atony or paralysis of the circular fibers and loss of tone. These gases are largely reabsorbed by the blood vessels or discharged with the feces. If these gases, in their downward passage, meet any obstruction, they are forced backward into the stomach and are discharged in this direction.

Another important source of stimulation to the coats of the bowel is the harsh indigestible particles of food which are not acted upon by the gastric juices. These also irritate and stimulate the contractions of the circular muscular fibres in the small intestine.

Of no small importance is the stimulus caused by a to and fro movement imparted to the bowel by respiration. The

excursions of the diaphragm upward and downward impart to the small bowel in particular, and also to the transverse colon, a movement which stirs up and churns, as it were, the intestinal contents. It changes the position of the bowel and helps to keep the intestinal contents on the move. It can be easily seen how anything which restricts the full expansion of the chest will interfere with the intestinal functions and assist in causing constipation.

The intestinal contents are fluid until they reach the ileo-cecal valve and by this time they are practically digested and nothing is left but those elements which have no food value. After they pass through the ileo-cecal valve into the cecum they become less fluid and, having to travel against the force of gravity, their movement in the large bowel is checked. Staying as it does in this portion of the bowel for some time, the fluid parts are gradually absorbed, and the nearer to the sigmoid the feces, the more solid they become. The mucous membrane of the colon is thicker and not so sensitive as that of the small bowel and requires more stimulation, consequently the stools are more solid in this portion of the bowel. If, however, too much vegetable fibre and undigested material is ingested, the colon tends to become over-stimulated and atonic; the fecal mass moves very slowly and the colon becomes over-distended and atonic, and chronic constipation, and sometimes fecal impaction, result. The fecal material, when it reaches the sigmoid, rests until ready to be passed out through the rectum and anus, as a fecal movement.

It can readily be seen that anything which interferes with the proper development and exercise of the intestinal muscle

layers will interfere with the proper movement of the intestinal contents and with expulsion at the proper time. In the first place, enough fluid must be taken into the system daily to keep the intestinal contents in solution and to properly supply the various organs of the body. People who do not drink sufficient water suffer from constipation because of the reabsorption from the intestinal tract and consequent hard and dry stools. People who drink great quantities of water with their meals drown their gastric juice; undigested particles of food are sent through the pylorus with great gushes of greatly diluted gastric juice; the feeble acid reaction of this mixture does not cause the proper reaction with the alkaline intestinal contents; proper amount of gases is not evolved and intensely irritating food particles are passed down the small bowel. This is another cause of loss of tone.

It is a well-known fact that carnivorous animals are constipated, while the herbivorous animals have full and frequent bowel movements. It therefore behooves us to see that a sufficient quantity of vegetable material which will leave undigested fibre in sufficient and not too great quantity, is incorporated into our daily regimen. It should also contain a sufficient quantity of mineral salts, which are natural laxatives. It should contain sweets, within certain limits, because of the gas development which goes with them and the fact that carbon dioxide gas is one of our best laxatives. Above all, it must not be a concentrated food; it must give sufficient bulk to the stool so that it will properly fill and distend the gut, give it work to do, and produce the proper mechanical stimulus to contraction. The value of whole wheat bread



lies in the quantity of cellulose in the husk, which is a very important element. People who eat too fast, causing improper digestion with improper bowel contents, have improper stimuli to peristalsis and consequently improper stools.

Outside of dietetic error, the most important cause of constipation is neglect. The school child hears the call of nature, the fecal mass is ready to be extruded, he is receiving powerful stimuli for the dilatation of the external sphincter, but in our modern schools the lesson hour is more important than the functions of nature. The child is not allowed to go and relieve himself. He restrains nature's efforts; the desire passes away. The continuance of this performance day after day soon makes the child a constipated child. For, while peristalsis is involuntary, in the vast majority of people the voluntary control over the sphincter is normally sufficient to withstand peristalsis. The strong expulsive efforts soon tire when retarded by a tightly contracted sphincter, and soon a constipated habit is induced. The young girl in society is taken with a desire to move her bowels and either because the time is not convenient and she restrains nature's effort, the desire soon passes away and she is constipated; or she may be willing to satisfy nature's desire but in order to reach the toilet room she must pass perhaps through a crowded room, and false modesty prevents her from allowing her friends to see her go in the direction of a toilet room. It seems to me that a very important provision in architecture of homes and institutions should be the placing of the toilet room in such an inconspicuous place that a person may reach the same without being subjected to the gaze of others. The business man,

the traveling man, the physician, the school teacher, the professional man, all refuse to obey nature's call because the time is not convenient, and thus we have a constipated nation, because we have not time to move our bowels when they want to be moved. I think this is the most important cause of constipation.

Another contributing cause to the voluntary repression of defecation is the fact that in institutions, and in large buildings, there are not enough toilet rooms for the number of inmates. Where one has to wait for his turn, as it were, the desire is soon lost.

The shape of the closet seat and its height from the floor are all of importance in the production of a good stool. The seat should be so made that the person using it is in a squatting position with the buttocks well separated so that free excursion upward and downward of the pelvic floor is allowed, and the full action of all the muscles involved in defecation brought into play. People leading sedentary lives who do not get sufficient exercise, of course, are constipated, as exercise is one of the important factors in keeping all bodily functions normal. There are many other causes which contribute to the production of constipation, but those mentioned are the most important.

When the bowel has become atonic, then remedies to restore their tone must be employed. In the treatment of acute constipation, cathartic drugs, suppositories, enemata, all have their proper place; but the victim of chronic constipation should no more be made a drug fiend than the victim of chronic appendicitis. Instead of causing irregular, erratic and violent peristaltic movements at certain times during the day, and in-

stead of changing from one cathartic to another and increasing the dosage, instead of taking away the work of the bowel by flushing with enemata; we should strive to bring that bowel back to its normal tone by imitating nature's methods. The only place for a cathartic in the treatment of chronic constipation is at the beginning of the treatment. When a patient consults you, complaining of infrequent or insufficient bowel movements, the first thing to do is to make a diagnosis between constipation and obstipation. The patient should be examined carefully, his abdomen should be palpated thoroughly; your female patient should have a bimanual examination; the male patient should have the genito-urinary organs examined, as many causes of constipation are reflexes from bladder and prostatic conditions. The rectum and sigmoid should be thoroughly explored and a complete proctoscopic examination is imperative in every patient complaining of impeded fecal movements. After you have satisfied yourself that you have a case of constipation, and not obstipation, to deal with, and after carefully questioning your patient as to habits, diet and previous history, the question of treatment presents itself.

Dietetic errors should be corrected and the patient instructed as to the time and the quantity and the kinds of food to take. If he is not able to properly masticate his food, he should consult his dentist. The teeth should be put into perfect shape. He should be instructed to drink from six to eight glasses of water in every twenty-four hours, the first glass on rising, the last glass upon retiring. He should drink between meals but not with meals. He should be instructed to eat a sufficient quantity of vegetable foods and

to eat the outside coverings of such fruits as pears, apples and peaches. He should be instructed to take outdoor exercise, to play tennis, to play golf, to go horseback riding, or bicycle riding, or to take long walks. He should take breathing exercises, and should develop his abdominal muscles. Any local condition such as hemorrhoids, which of themselves do not cause constipation but are caused by constipation, and by their presence prevent natural movements, should be corrected. Fissures, ulcers, or excoriations of the anus should be treated locally. Proctitis should be relieved by the proper sprays and medications applied locally. Run down patients should receive massage from a properly qualified masseur. The abnormally tight sphincter should be dilated or given vibratory massage, and the atonic lower bowel should be properly massaged.

The author has been using a method of internal massage and dilation of the sphincter which is very simple and which has been most successful in his hands. The principle is not new. It consists in the introduction into the rectum and sigmoid of sausage shaped pneumatic rubber dilators. These are dilated to conform to the shape of the rectum or sigmoid, by means of low compressed air pressure. This dilatation is carried to a point where the patient feels a fullness and the dilator is alternately inflated and deflated and manipulated so that the mucous lining of the bowel is stimulated and the circular muscular fibres contract and gradually regain their tone. Cases of chronic constipation of years' standing have been successfully treated and cured in from one week to two months' treatment, the longest case not requiring over twenty-five treatments to establish a perfect cure.

Normal defecation usually follows within a few hours after the first treatment.

These pneumatic dilators the author has made from a rubber bag shaped like a condom and they are mounted on a Wales bougie, sizes 5 to 7. These are attached by means of a cut-off valve, to the compressed air apparatus, at a low pressure, and are slowly expanded and allowed to empty themselves. These treatments do not last over five minutes at a time and are followed by good expulsive efforts.

The patient is allowed and encouraged to go about his work and is not obliged to carry any extraneous substance, such as cotton wool or gauze, around in his rectum or sigmoid for from one to six hours, with tapes, tags or strings protruding from the anus. He has received sufficient stimulation, applied directly to the rectum or sigmoid or to both, in a few minutes, and with decided happy and permanent results.

The simple pneumatic dilator devised by the writer, being mounted on a firm but flexible shaft, is introduced into the rectum with the patient in the Sims' position, and without the need of the speculum or proctoscope.

In simple enlargement of the rectal valves, due to proctitis and congestion, where there is no deposition of fibrous tissue, pneumatic massage with this dilator will speedily effect a correction of the condition.

In unusually resistant sphincters,

gentle dilatation with this instrument, along with digital massage and kneading of the external sphincter muscles, quickly corrects the condition.

The only medicinal agents prescribed, and these only in occasional cases, are strychnia, before meals, as a tonic and pancreatin in five or ten grain doses, after meals, to correct intestinal indigestion, when present at the onset of treatment. The only time when the administration of a laxative or enema is permissible, in the treatment of chronic constipation, is to empty the bowel of its hardened contents at the beginning of the treatment, and only then!

When, after studying your patient, his habits and history, and after a proper proctologic examination, you have made a diagnosis of chronic constipation in contradistinction to obstipation, then you may be certain that you have a case which will respond favorably to the treatment I have outlined. The important point which I wish to impress particularly on you, in closing, is to first make your diagnosis between the obstructive condition from the mechanical causes enumerated above, obstipation; and the purely functional diseased state known as constipation.

In conclusion, the writer wishes to state, that he has yet to meet a case of true chronic constipation, in which he has had the co-operation of the patient, which has resulted in failure.



## HEALTH OFFICERS, THEIR DUTIES AND RESPONSIBILITIES IN CONTAGIOUS DISEASES.\*

F. W. SHUMWAY, M. D.

It is a fact, and I think one that is recognized by the profession generally, that the health laws on our statute books today need a general revision. They are, in many instances, too liberal in construction and not specific enough in details, complicating to a great extent the working of the law, as, for instance, allowing one class of men to pass upon accounts contracted by other men or bodies of men, as boards of supervisors auditing accounts contracted by local boards of health; again, allowing local boards of health to carry out restrictive measures, under such rules and regulations, as they, themselves may adopt. Then, again, while the courts have been very liberal in their interpretation of the law, recognizing as they do that health boards are, in a sense, emergency boards, organized to meet and combat emergency conditions, for the protection of the public, and while the law names only three diseases as especially dangerous to public health, smallpox, diphtheria and scarlet fever, and concludes with "such other communicable diseases as are dangerous to public health," etc., the law, in this particular, is not specific enough, for under it the State Board of Health has assumed the right to say what these other diseases are, and as a result, we have a list of ten or more diseases classified as dangerous to public health, all of which I know do not appeal to the profession, at large, as being especially dangerous.

The law specifies smallpox, but we all know that the mortality rate is many times greater in consumption, pneumonia,

typhoid fever, and in fact, in all of the other communicable diseases, than in smallpox.

So, I say, our health laws today, as they stand on the statute books, are inadequate for present conditions, and should be re-enacted, and in my judgment, the power to determine what diseases are especially dangerous to public health, should be vested in a board or commission of the best medical men of the state, who are in active practice, and able to pass intelligently on this question. Were this done, the State Board of Health, the local boards of health, and the physicians at large, could work more in harmony, and better results could be obtained.

Understand, I am not saying these things in a spirit of criticism, for our present law is far and away ahead of no law, and great good has resulted from it, but as a general practitioner for twenty-four years, twelve or thirteen of which, I was a local health officer, then coming into my present work, I believe I appreciate the defects in our present system more than the average physician, and the reason there has not existed more cordial relations and co-operation in our work.

The work of sanitation, as carried on by the health officials, is distinct from that of the physician, but none the less important. The physician combats disease after it has attacked the system, the sanitarian or health officer combats

\*An address delivered before the Ingham County Medical Society, January 11, 1906.



causes and conditions which produce disease. It is a distinct school, that of preventative medicine, but it cannot be successfully carried out without the co-operation of the active practitioner.

Recognizing, as we must, that in the list of contagious diseases dangerous to public health, some are much more so than others, requiring more detailed work on the part of the health officer, yet in all cases of a contagious character, the duties and responsibilities of the local health officer are great, for upon him devolves the task of inaugurating and carrying out proper restrictive measures, to the end that the public may be protected. But his work can avail but little, without the active and intelligent coöperation of the profession at large. And I want to say right here, ladies and gentlemen, that we as medical men and women, in active practice, are under obligations to the public along these lines. In a measure, I can understand why this is so, and as a profession why we have not taken the interest in these matters that we should, and it is to discuss them, and if possible bring about more concerted action between the health department and the profession to the end that public health matters may be better subserved, that I speak of these things.

Now, I am not going to quote law to you, for I assume you are all familiar with its provisions. In justice to the local health officer, upon whose thoroughness in the performance of his duties, largely rests the success of restricting these diseases, as well as in justice to our own patients and the public at large, when we are called to a patient, suffering from some contagious trouble, we should report the same to the health officer as soon as a positive diagnosis is established, and

not wait until the patient is dead or has recovered. By so doing, the health officer can inaugurate measures that will be of some value, whereas, if we wait a day or two, or even longer, valuable time is wasted and we fail of results.

I speak of this phase of our duty, at this time, not in criticism, for as a general thing, I believe the physicians, in Lansing and vicinity, are pretty good at reporting cases; but I know throughout the State, many instances, where the first knowledge a health officer has of a dangerous disease occurring in his jurisdiction, is when a death is reported to the Vital Statistics Department and we write the health officer for final report on the same, possibly a month or longer after death, precluding any effective action on his part, toward restricting the same, and unless the attending physician has disinfected, the public is little, if any, protected.

To return to my subject—Assuming that the physician has done his duty and reported a case dangerous to the public health, it then becomes the duty of the health officer to immediately investigate the case, and institute such measures toward restricting and preventing the spread of the disease, as the case demands. And right here you will pardon me if I digress a little and state my position on the subject of precautionary measures to be taken, for I recognize I am in some respects going against long established rules and regulations, as laid down by the department with which I am now connected.

It has been the policy, in times past, to list certain diseases as dangerous to public health, and outline restrictive measures, such as isolation, disinfection, placarding, quarantine, etc., to apply to all.

With this policy, I take issue as being impracticable, inconsistent and not appealing to the profession as necessary in all cases and, therefore they are not carried out. For instance, we have as these diseases, smallpox, diphtheria, scarlet fever, pneumonia, typhoid fever, consumption, measles, whooping-cough, influenza (*la grippe*) and meningitis, and as these diseases differ in the degree to which they are dangerous to the public health, so in my judgment should the means employed to restrict them, differ in like degree.

In smallpox, diphtheria and scarlet fever, all the known restrictive measures should be employed. Placarding, isolation, disinfection, quarantine, etc., together with vaccination in cases of smallpox, use of antitoxin in diphtheria, and if the epidemic be severe, a closing of schools, churches and public halls. In pneumonia, typhoid fever, meningitis and consumption, where the infection is limited to the discharges, if the patient and attendants can be isolated from the rest of the family and kept so, all of the discharges thoroughly disinfected before being disposed of, and complete disinfection of the room or rooms, in which the patient is confined, with all their contents, at the termination of the disease, then and in that case I do not consider it necessary to quarantine the entire premises, nor keep the children out of school. As to placarding in these cases in order to give the public notice, I would leave that to the discretion of the local health authorities, for a great many object to placards in these cases, and it can best be handled by the local health officer and attending physician.

In measles, whooping-cough, influenza, rotheln, chicken-pox, etc., isolation and disinfection, if properly carried out, are

about all that can reasonably be advised; to placard and quarantine would, in many instances, take in the entire community. Physicians in general do not consider diseases in this class of sufficient importance to even report them, to say nothing of observing necessary precautions, and I have found it useless to advise, unless the course suggested appeals to them. I do believe, however, with a proper classification of these diseases dangerous to public health, and of the measures to be adopted for restricting them, the profession will coöperate more fully with the health authorities, and better results will be obtained along these lines.

The health officer should, at all times, be prompt in action, as even a few hours' delay may result in general exposure, thorough in detail, and active in seeing that the proper restrictive measures are carried out.

Warning the public by placards or otherwise, isolating the patient infected, quarantining those who have been exposed during the period of incubation, urging (and I wish he might be able to insist) on vaccination in smallpox, of all, whether exposed or not, as vaccination and revaccination are the only measures which will stamp out smallpox.

The health officer should also notify principals and teachers of schools, of families where contagious disease exists. He must see that persons under quarantine do not suffer from lack of nurses, food or other necessities. He must supervise funerals of persons dead from contagious diseases, and disinfect or supervise the disinfection of rooms or premises, clothing and all articles likely to be infected, before allowing general use of them. He must, at all times, keep the president of his local board, and the secretary of the

State Board, constantly informed respecting the outbreak of every disease dangerous to the public health, occurring in his jurisdiction, also all the facts that may come to his knowledge respecting the source of contagion, whether brought into his jurisdiction from outside or occurring locally, as in the water-supply, etc.; if from suspected water-supply, he should advise the boiling of the water before using, pending a bacteriologic test of the suspected water.

At this time I want to call your attention, and if it appeals to you as it does to me, secure your support in an effort to be made at the proper time, to establish a chemic and bacteriologic department in connection with the State Board of Health, here at Lansing. If this can be done, it will insure a great saving in expense to the physicians throughout the State, or to their patients, many of whom can ill-afford the expense of laboratory examinations, and further, it will insure a report based upon an analysis made by an expert.

The Upper Peninsula Medical Society, comprising the entire upper peninsula medical profession, passed resolutions, unanimously, endorsing this movement, at its last annual meeting, August 9 and 10, 1904. The Gratiot County Medical Society has, by resolution passed at its November meeting, endorsed it, and before the year is out, I hope to have the majority of the physicians of the State with me on the proposition, for it is one I believe that appeals to them.

Returning again to my subject, there are other and varied duties devolving upon the health officer, as the abatement of all nuisances, issuing permits for shipment of disinterred bodies, or bodies dead from a contagious disease, granting per-

mits for the same to enter his jurisdiction, etc., all these and more the health officer is called upon to supervise, and when we consider the very meager salary which is allowed him, considering the importance of his work, it is not strange that sometimes he neglects and slights his work, owing partly to this fact, and partly to the indifference of the physicians in practice in not coöperating with them. This condition obtains more particularly in the rural sections, where the local health boards fail to appreciate the importance of this work.

There are thousands of dollars spent every year in combatting smallpox after it has made its appearance, while it would be impossible to get that many hundreds of dollars allowed for restricting any of the other contagious diseases, any one of which carries a far greater mortality rate than does smallpox. This is shown in the following table: (Page 218).

For these and other good reasons, which must appeal to you, I would most earnestly urge upon the profession their hearty coöperation with the health authorities in this most important work, for I find it very difficult indeed to interest the masses in these matters, when the physicians themselves are indifferent.

There are other and just as important matters, as those I have touched upon, that, as physicians, should demand our attention and support, notably, this spitting nuisance. The American people are very much given to this habit; we are expectorating our lives away. The first thing a boy learns to do is to **walk**; the second, to spit over the banisters. Then the front tooth opens up fresh possibilities which lasts until corn-stalk cigarettes appear; after that the habit may be said to be formed, so that by the time he

**DEATHS IN MICHIGAN FROM THE FOLLOWING DISEASES FOR A PERIOD OF  
4 YEARS, 1901-1904.**

Diseases	1905	1904	1903	1902	1901	Average
1. Pneumonia.....	Data not Compiled	2685	2659	2637	2901	2720
2. Consumption.....	"	2648	2202	2088	2152	2272
3. Influenza.....	"	690	517	373	1254	708
4. Typhoid fever.....	"	633	601	608	645	622
5. Diphtheria.....	"	512	684	504	502	550
6. Meningitis.....	"	396	496	489	520	475
7. Scarlet Fever.....	"	206	200	277	312	249
8. Whooping-cough.....	"	145	381	289	163	244
9. Measles.....	"	193	180	238	79	172
10. Smallpox.....	"	27	29	42	27	31

can vote he is the "real thing," and the first thing he looks for on entering a room is a place to spit. It must be a soul-satisfying pastime, since so many men indulge in it to excess. I have seen men, in the presence of ladies, use in place of a cuspidor an empty fire-place, the polished floor, or even the hot-air register. There is no more fruitful medium for the spread of disease germs than the sputum, and yet you will see it deposited on our sidewalks, in street cars and other public conveyances, in public halls, churches and even in homes. It is a self-evident fact, that if we could thoroughly disinfect all discharges at all times, and under all circumstances, typhoid fever would be eliminated. Equally true, if the sputum could be taken care of properly, consumption, pneumonia and kindred diseases would be greatly lessened. I would like to inaugurate a crusade against this spitting habit, in the interest of decency and health.

One other subject I would like to speak of, and that is medical inspection of

our public schools. It is working great good in the cities that have it in force, and in my judgment it ranks next in importance to isolation and disinfection in the restriction and prevention of disease. Several cities in our state have adopted this, notably, Detroit, Ann Arbor, Grand Rapids, etc.; the results are most satisfactory to teachers, pupils, and the public generally.

I would be pleased to have an expression from this society, as it is a matter that is being taken up and adopted by other cities in our State, and as progressive and up-to-date as Lansing is in all other matters, I want to see her abreast of the times on health matters as well, for there is no more vital question that comes so near the homes of all of us, than this health question, especially when it has to do with our children.

I would be glad to welcome the physicians of the state, and especially of this society, to the department with which I am connected, at any time, for in a way, it is your department, created to assist the physicians in their work,



**Clinical Observations in Exophthalmic Goiter.**—By George Dock. The observations are based on 32 hospital cases observed in the course of ten years; 29 were women, 3 men. The predisposing causes could rarely be discovered. In 12, previous diseases or nervous shock were noted a short time before the characteristic symptoms. In these cases goiter was the first symptom, but in 12 others there was a goiter observed from 3 to 37 years before the other symptoms came on. The thyroid gland was enlarged in all cases. In 26 a systolic murmur was audible over the thyroid. Tachycardia was present in all but 2 cases, and in one of these had been present before the observations began. Observations on the blood pressure showed striking differences. In some the pressure was high, up to 180 mm. Eye symptoms were absent in only three cases. Emaciation was marked and striking symptom, in two cases amounting to almost or quite half the body weight. Diminution of hydrochloric acid in the stomach was observed in a number of cases, but hypermotility was often associated with this. Two of the patients died; one from complicating disease, the other with acute symptoms. Of the other cases, a number had chronic courses up to 15 years. Emphasis is laid on the importance of the early diagnosis. Regarding treatment, rest is considered most important, with symptomatic treatment. Experiences with some of the organic preparations and roentgen rays are mentioned. Surgical treatment is recommended, with certain limitations.—*American Medicine*, February 24, 1906.

**Splenic Luekemia.**—H. J. Thompson reports the case of a teacher, thirty years old and single. Her past history did not show any severe illness. In December, 1901, she had "nervous spasms," the result of overwork, and shock, occasioned by the sudden death of her sister. In December of the same year, she awakened one morning and found that she had lost the use of her limbs, and was in bed three weeks. Later on she regained the use of her limbs a little, but was very weak, with a pain in her left side, and soon after observed a growth on that side of the abdomen. In December, 1903, the skin was very dark in color over the abdomen; the menstruation had stopped several months before, and the kidneys were sluggish. The first Roentgen-ray treatment was given September 10, and continued once in five days until the end of the year. The menses reappeared immediately afterwards. All the treatments were given in a recumbent position, the patient being unable to sit up; a moderately hard tube was used, over the splenic region only, for fifteen minutes. As the treatments progressed, the symptoms abated, and soon after the patient returned home. In April she was able to walk without assistance, she gained flesh, and the menstrual periods were regular. From April until June she received three Roentgen-ray treatments a week. She returned home in June, lived out of doors all summer, and improved sufficiently to assist with the housework. Her weight increased to one hundred and thirty-seven pounds, and her waistline was reduced so that she could wear a blouse and belt, instead of a loose gown.—*Medical Record*, March 3, 1906.

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APRIL, 1906

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### Editorial.

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#### LAW VERSUS MEDICINE.

A pleasing illustration of coöperation between lawyer and doctor, is the recent action of the Chicago Bar Association, in requesting information from the Chicago Medical Society, regarding unprofessional conduct of any member of the Bar Association. This request was elicited by the action of a certain attorney in soliciting from medical men, personal injury cases, on a contingent basis and offering 25% of his fees to the doctor. The Bar Association, having for its purpose, among other things, the maintenance of honor and integrity in the practice of law, believes this to be unprofessional and tenders its services to the Chicago Medical Society, not only in reference to this particular matter, but in any other which will aid in the objects of the organization.

Instances of this nature, illustrative of the inter-dependence of two great learned professions, are especially pleasing to us as indicative of the dawn of a better understanding between lawyer and doctor.

The medical expert, often unqualified for his self-assumed position, has frequently been made the butt of legal sarcasm and ridicule and rightly so, but in the main, the courts and reputable attorneys are pre-eminently fair to members of

the medical profession, when testifying as to matters of fact and experience, and only when the doctor elucidates unfounded theories from a biased standpoint, often basically commercial, is he subjected to verbal indignities.

The gradual assumption of control of expert testimony by the courts, at the instance of both bar and medical associations, bids fair soon to place medical expert testimony upon the plane where it belongs.

In addition to the reformation of expert testimony and the elimination of unprofessional commercialism in personal injury cases, there remains one important step to be taken in the coöperation of lawyer and doctor, i. e., the protection of the doctor against the legalized blackmail, to which he is subjected at the hands of many lawyers, by reason of suit or threat of suit for alleged malpractice.

Inasmuch as the doctor is legally accountable for the possession of but an *average* amount of knowledge and skill, instances of actual malpractice are rare and yet, 5% of American physicians are, each year, harassed by suit or threat of suit for alleged negligent or unskillful treatment.

The usual underlying cause of these threats, as is also true of most personal injury cases, is the zealous desire of attorneys to get business, even though on a speculative basis. Business done on the no cure, no pay basis, is hardly professional for the doctor. Why, then, is it professional or even justifiable for the lawyer?

The docket of every court in the land is crowded with *bluff* cases in which no negligence can be shown on the part of the defendant corporation or individual, where the plaintiff's attorney incites the

action and advances the nominal fees, on the possibility of getting a compromise settlement without trial. If bond for costs, to the amount of even one hundred dollars, were exacted by the courts, this class of litigation would be limited to the occasional just claimant, and no one suffer thereby, except the ambitious lawyer.

While our viewpoint may be biased, it would seem to us a legitimate function of bar associations, to formulate a code of ethics, having for its object, the limitation, if not suppression of this class of business. It is certainly true, that because of this menace, it has become necessary, that most corporations and many physicians carry insurance for protection or protect themselves by organization for mutual defense.

Several insurance companies are now writing policies, offering physicians more or less adequate protection, and everywhere, interest is awakening in local or state plans for self-defense. The Chicago Medical Society and the Wayne County (Michigan) Medical Society, through its Defense League, being pioneers in this work. The Chicago Medical Society is fortunate in being able, by reason of its large membership, to defray the expense of defense from its own treasury. The Wayne County Defense League has its own dues and funds, and its plan is adaptable to every society, however small.

The local plan of defense offers protection which no insurance company can furnish by reason of the consolidation of interests and *esprit de corps* engendered thereby, and at merely normal cost.

Speaking for our local organization, it can be said that the Defense League has solved the problem of getting started, that it is financially strong enough to

*guarantee* the promised defense, and is ready, at any time, when feasible, to allow the District or State Society to take up and carry on the good work which it has so well inaugurated.

In thorough organization, lies the keynote of success; and the sponsors of the local plan will hardly feel satisfied until every physician in the state has the self-protection which we locally enjoy.

Then, suits for malpractice will be limited to the rare cases of evident, instead of alleged, negligence and the shyster lawyer will perforce seek an honest living or other fields of prey.



### "AMONG OURSELVES WE FREELY DISCUSS IT."

One evening during the past month, there appeared in the *Detroit Journal*, a shameful paragraph, which purported to be the statement, made to the police, by a certain physician in Detroit, who had been apprehended for performing a criminal operation. The physician is quoted as follows:

"There is nothing out of the way about that. It may be legally wrong, but morally there isn't anything the matter with it, as long as there is no life at stake. We do that kind of thing right along and while we physicians may publicly deny it, among ourselves we freely discuss it and admit our work along that line."

One statement in the above is as true as the others are damnably false. "Among ourselves we *are* freely discussing it;" we are discussing what shall be done with just such criminals as this physician is alleged to be. But are we doing anything to prevent it?

Is the practice of criminal abortion on the increase, as many claim it to be? So far as we know, no estimates as to its frequency in Michigan cities have been

made, but judging from the figures as given for Chicago, where Bacon believes that from six to ten thousand are done annually, there must be very many performed here in our own state. Every practitioner constantly hears of cases; no less than five cases came to our personal notice, in one way and another, last month. We believe that the number is increasing, not perhaps among the unmarried but among the married. This increase is largely due to the conditions of present day life, prevalent especially in the large cities. The number of apartment houses in Detroit which advertise "No children, no pets, no pianos" is daily increasing. The number of should-be parents who have neither the time nor the inclination to raise a family, is increasing.

The cause which produces the demand for abortions is social, and the remedy which would strike at the root of the demand, is also social. The profession has recently taken up a crusade against the prevalence of venereal disease, a duty long deferred. We should not be longer remiss in dealing with this other evil. We should take the initiative in aiding the criminal authorities to catch and convict the scamps responsible for these operations. If the great weeklies, such as *Collier's* and *The Ladies' Home Journal*, periodicals having tremendous circulations and far reaching influence, were to take this matter up as they have that of its little sister evil, the use of patent medicines, much in the way of education and enlightenment might be accomplished.

But to return home. *The Free Press* of Sunday, March 4th, contained no less than twelve advertisements which undoubtedly call attention to abortionists and abortifacients. Several others prob-

ably belong to this class, but in them the meaning is purposely somewhat veiled. Such advertisements are illegal, or ought to be. It is at least illegal to employ the mails in the sale of abortifacients.

Besides those who advertise there are certain men and women in Detroit—and what is true of Detroit is also true of every other city in the state—who are known to habitually perform abortions. We keep them—usually—out of our medical societies, but thereafter wash our hands of them and let them go their own way, plying their nefarious trade, unmolested. "Among ourselves we freely discuss it," and that is all.

Our duty is plain. The methods to be adopted for doing our duty are not so plain. We can at least do as we did with the subject of venereal disease. At the next meeting of the State Society, a small committee of interested men should be appointed, to study this subject. Such committee should have authority to appoint sub-committees in every part of the state. They should see to it that a symposium on the subject is held in every county society during the next twelve months, that the local papers are asked to co-operate, that the postoffice authorities are aroused, and that some of the lay papers which are so courageously fighting great evils, are asked to take up this matter. In these and in other ways, some good might perhaps be accomplished. Anyhow, we ought to do more than "to freely discuss it among ourselves."



### THE SEVENTEEN YEARS' WAR FOR PURE FOOD.

The Heyburn Pure Food Bill passed the Senate on February 21, and a great victory was thus gained by those who



have fought so long for this much needed reform. It has been a struggle lasting for seventeen years. While it has not yet of course become a law, the prospects for its passage are better than ever before.

The vote in the Senate was 63 to 4, and it is fair to assume that the four Southern Senators who dissented did so, not because of their opposition to the provisions of the bill, but because they believe it conflicts with State rights. And yet this apparently almost unanimous vote does not mean that all the Senators favored the bill, for several amendments, which, if carried, would have made the bill practically inactive, were lost by a narrow margin. The patent medicine men and the liquor men had strong influence, but it was not sufficiently strong to kill the bill.

The Heyburn bill makes it unlawful to manufacture or sell adulterated foods, medicines or liquors within the District of Columbia, the Territories or insular possessions of the United States and a misdemeanor to ship such commodities from one State to another. Any provision beyond this would be interfering with State rights and hence unconstitutional. Many States, however, have pure food laws, so that if fortune (or hard work) favors the final passage of the bill, much good will have been accomplished.

The opportunity for obstruction in the House is less than in the Senate, for once the Administration and Committee on Rules are committed to a measure, little short of an opposing majority can defeat it. We cannot believe that the Administration looks upon this measure with disfavor, and we hope that the Committee on Rules may not do so. However, the bill, at this writing, has not been reported out of Committee and every physician

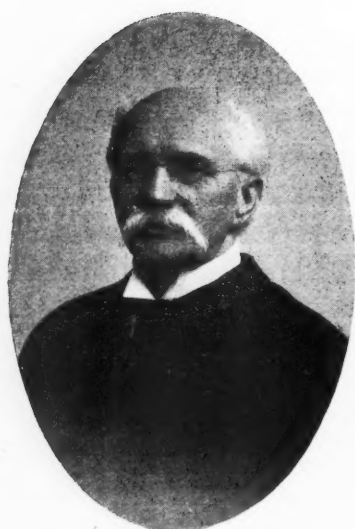
should see to it that a line is sent to his congressman, asking him to support the measure. Watch for the final vote and if he does not, let him hear from you.



In another column will be found the announcement of a prize essay competition offered in the interest of Cremation. While the personal beliefs and preferences of an individual are usually based on early training and environment, there is no doubt that considered as a sanitary measure, cremation is entitled to earnest consideration by the medical profession. There is no class of men, we are told, who favor cremation so universally as the medical profession. While this is but to be expected, from their opportunities of seeing the distressing sequences of the outdoor exposure of the living at an earth burial during inclement weather, and from their knowledge of the loathsome features of the slow combustion of the body, as effected by the elements, their knowledge of these and other facts should induce them to give this sanitary reform their support and to assume a more active part in this movement of hygiene. Health officers and boards of public health should encourage discussion of this topic in order that the laity may more fully appreciate the situation.



The American Medical Association will meet in Boston, June fifth to eighth. The rates have not yet been fixed, but it is altogether probable that the usual "fare and a third for the round trip" will be in force. If a large enough party can be made up and a time for departure, probably Sunday, June 3, agreed upon, special cars will be run from Detroit direct to Boston. No better opportunity for a trip east than this!



### FORTY YEARS OF SERVICE.

On March 8th, some two-score medical friends gathered together at a banquet, in Detroit, to celebrate the fortieth anniversary of Dr. Johann Flintermann's doctorate.

The gathering was a spontaneous one, those present being actuated by the one purpose of paying their respect to and showing their appreciation of one who has worked unceasingly and with marked honor in the community for forty years.

The system, thoroughness and circumspection, which have ever stamped Dr. Flintermann's work, have won for him the well-deserved reputation of a keen diagnostician and have served, for many years, as an inspiration to those with whom he has come in contact. As a token of this debt which the Detroit profession owes, a beautiful copy of a somewhat rare edition of Dante was presented to Dr. Flintermann, and was graciously accepted in a speech filled with gratitude and feeling.

The members of the State Society are a unit in extending congratulations to Dr. Flintermann. A man of lofty ideals, unassuming, modest and sincere, he has al-

ways had before him, the first duty of the physician, as expressed in the maxim *Salus aegroti summa lex est*. They are indeed the true physicians who, like him, enter the home of a patient, prepared with the necessary knowledge, imbued with the feeling of the great responsibility and determined to loyally fulfill their obligations.

The medical profession of Michigan, as well as the public, has reason to be thankful that we have among us a man with ripe experience who is still young and whose years of usefulness and inspiration will still be many.

Gesundheit!

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### Book Notices

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**The Practice of Medicine.**—A textbook for practitioners and students, with special reference to diagnosis and treatment. By James Tyson, M. D., Professor of Medicine in the University of Pennsylvania, and physician to the Hospital of the University; physician to the Pennsylvania Hospital, etc. Fourth edition, revised and enlarged, with 240 illustrations, including colored plates. Octavo, pp. 1350. Philadelphia: P. Blakiston's Son & Company, 1012 Walnut St. 1906. Price. Cloth, \$5.50.

This new edition of Tyson's Practice is even better than those which previously appeared and this is saying much. The author has taken the opportunity to revise a few minor points and to make additions which recent progress has rendered necessary. Numerous illustrations have been added and there are now some 240 of them which elucidate the text and add to the interest of the reader.

The section on nervous diseases, revised in the third edition, by Spiller, remains one of the best and most readable of the short treatises on this—the most difficult subject in internal medicine. The chapters treating of animal parasites, have been enlarged and brought up to date by Allen J. Smith, a recognized authority on the subject. This section is profusely illustrated.

Throughout the book, especial attention has been given to diagnosis, pathology and treatment. The paragraphs relating to treatment are particularly full and interesting—more so than in any other similar work. Not only in medical treatment fully covered, but hydrotherapeutics and

physiotherapeutics are given full notice. The author's own preferences are explicitly expressed, giving the work the stamp of authority, often lacking in books which are prepared by compilation and not founded on actual experience. We venture to say that it is this feature, more than any other, which originally accorded the book instant recognition, and which has made four editions necessary within a comparatively few years.

The arrangement of the sections is systematic. After the definition of the affection to be treated, a comprehensive historical note appears in fine print. Etiology, pathology, symptoms, diagnosis (including most excellent sections on differential diagnosis), and treatment are all taken up *seriatim*. A judicious use of bold face type and italics makes ready reference easy. This feature, in conjunction with the full index, renders the work a splendid one for reference, and will be appreciated by him who runs and reads.

On the other hand, the simple and forceful English, which characterizes the author's style, makes easy and delightful reading for him who sits down for a quiet hour of study. Of 1,260 pages, not one is dull.

The type, paper and binding are all excellent.

The work will continue, as in the past, to represent the best of American Medicine, in other words, the best of modern medicine.

**Diseases of Infancy and Childhood.**—By L. Emmett Holt, Professor of Diseases of Children in the College of Physicians and Surgeons of Columbia University, New York. New, third edition, 6x9½ in., 1170 pages, illustrated. Cloth, \$6.00. New York: D. Appleton & Co. 1906.

The author's reputation is, in itself, sufficient recommendation of the new third edition of his book. But the excellence and completeness of the work cannot but elicit an expression of the sincerest approval from students of this subject, who will find it an invaluable aid.

The purpose of the author, in presenting a book for the student and practitioner, has been closely adhered to. The result is a concise, readable and thoroughly practical volume.

In this new edition, much of the matter in the two previous editions has been revised, and to it, valuable additions have been made, of which, the paragraphs on the subject of general anaesthesia are by no means of least importance.

Much new space is devoted to the topic of artificial feeding of the infant in health and in illness—a subject about which too much cannot be known, as the welfare of the child's future depends upon it to such a marked degree. Into this chapter, as into others, new charts have been in-

troduced for purposes of elucidation, and a number of the old illustrations have been improved, greatly augmenting the attractiveness and value of the work.

Among other revisions may also be mentioned, the article relating to the physical examination of the child, to which much has been added.

The brief additions to the chapter on rheumatism are of interest and the extra lines bearing upon diabetes accord with the general views at present held.

This edition contains about fifty pages more than the one preceding it, but notwithstanding the magnitude of his subject, the author has not digressed, but has given those topics consideration which are only essential to an up-to-date work on pediatrics.

That this text book has now passed its fiftieth thousand, is sufficient evidence of its excellence. It will long continue to be the standard English work on the subject.

**International Clinics.**—Vol. IV. Fifteenth Series, 1906. Cloth, 6½x9½ in., 312 pages; numerous illustrations. Philadelphia: J. B. Lippincott Company.

The last volume of this well known publication is somewhat delayed on account of the printers' strike, universal over the country. It contains 25 articles from the pens of men, for the most part well known, and with two exceptions, these articles are excellent.

Gottheil's contribution on the Treatment of Psoriasis is a good one and splendidly illustrated. Gwyn, of the University of Pennsylvania, presents a thoughtful and practical paper on the Treatment of some Common Gastric Disorders; Brown reviews our knowledge to date of the thyroid and the treatment of its anomalies, bringing out clearly the clinical application of the more recent work on the parathyroids. Craig's paper on Malta fever is an excellent contribution to the subject.

Among the surgical papers is one by Deaver, on the Results of Operations, in the Treatment of Diseases of the Stomach. A very convincing argument is set forth, showing that the surgical treatment is far more successful than the medical in various gastric diseases, notably in ulcer.

That Deaver's opinion is not prejudiced, is evidenced by the following sentences. "Nor do I approve of operation for all varieties of hemorrhage which may occur in the course of non-obstructive gastric ulcer. I think it pure madness to operate while the bleeding is actually taking place, with an idea of finding the bleeding point and ligating it."

Another paper worthy of notice is that of Freiberg, which presents some original work on the clinical course of joint tuberculosis, studied by means of radiographs.

Several gynecologic papers are included.

The two papers in the section on pathology are the best in the book. Warthin, of the University of Michigan, gives the results of an extensive piece of work, undertaken to determine the effects of Rontgen Rays upon the blood forming organs. We have space for but one of the ten conclusions, namely: "Based upon these studies, the therapeutic use of Rontgen Rays in Leukemia seems of doubtful value or even dangerous. Careful clinical and pathologic studies will be necessary to establish the fact of a positive cure in any case."

Simon contributes an excellent article on Eosinophilia.

In a series of monographs, such as are presented in these volumes, the authors should be more particular in giving references, for they would greatly add to the value of the work. A few papers, including the two last mentioned, are exceptions to the rule, in that they contain a complete bibliography.

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**The Ophthalmoscope and How to Use It.**—By James Thorington, A. M., M. D., Professor of Diseases of the Eye in the Philadelphia Polyclinic, etc.  $5\frac{1}{2} \times 8\frac{1}{2}$  in., 298 pages, 73 illustrations, 12 colored plates. Price \$2.50. Philadelphia: P. Blakiston's Sons & Co. 1906.

Although many believe that the ophthalmoscope is an instrument to be used only by the ophthalmologist, it is true that every man who practices internal medicine and particularly he who sees many patients suffering from nervous disorders, should not only be familiar with its use but should also be able to employ it himself.

This little work of Thorington has succeeded well in giving those directions which are necessary for the novice, for the text is clear and systematic and the illustrations faithfully portray the conditions, both normal and pathologic, with which the practitioner meets.

The first four chapters deal with the various forms of ophthalmoscope, the methods of examination, the estimation of refraction, the anatomy and anomalies of the eye and the normal eye grounds. In Chapter V, the structural alterations or changes which are indicative of disease are gone over *seriatim*. The important subjects of vision fields and perimetry are fully treated in Chapter VI. The remaining pages deal with the diseases of the retina, optic nerve and choroid, with a separate section on glaucoma.

The text is well written and edited. The colored plates are from the brush of Margaretta Washington—a guarantee of their excellence and reliability.

The book should be in the hands of every one who wishes to perfect himself in this important method of diagnosis.

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**The Physical Examination of Infants and Young Children.**—By Theron Wendell Kilmer, M. D., Adjunct Attending Pediatricist to the Sydenham Hospital; Instructor in Pediatrics in the New York Polyclinic Medical School and Hospital, New York; Attending Physician to the Summer Home of St. Giles, Garden City, New York. Illustrated with 59 half-tone engravings. 12mo., 86 pages. Bound in extra cloth. Price, 75 cents, net. F. A. Davis Company, Publishers, 1914-16 Cherry street, Philadelphia, Pa.

The physician who has to deal with infants and young children, and there are few who do not, will find this little book of Kilmer an interesting and helpful one. The idea of the book is not to exhaust or to even outline methods of physical examination in general, but merely to draw attention to the application of these methods to children and to point out wherein they differ from those employed in the adult.

In chest examinations, the author seems to lay more stress upon auscultation than upon percussion. Many would disagree with him on this as well as on the use of the percussion hammer, which is advocated in preference to the finger. Light percussion is the all essential method when examining the chest of a baby, and surely the finger method brings out the notes, in light percussion, more perfectly than does the hammer. However, these are very minor points, about which there are differences of opinion. On the whole, these chapters are excellent.

Examination of the throat, nose, eyes, ears, the method of obtaining blood specimens, stomach washing, lumbar puncture and laboratory examination of milk are briefly but clearly covered and well illustrated.

The book is well worth the price.

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#### Books Received.

- International Clinics, Vol. IV. 15th Series, 1906. J. B. Lippincott Company, Philadelphia.
- The Ophthalmoscope and How to Use It. By James Thorington. P. Blakiston's Sons & Co. Philadelphia.
- The Physical Examination of Infants and Young Children. By T. W. Kilmer. F. A. Davis Co. Philadelphia.
- Modern Clinical Method. Vol. II. Diseases of Metabolism and of the Blood. Animal Para-



sites, Toxicology. Edited by Richard C. Cabot, M. D. Instructor in Clinical Medicine at Harvard University. 650 pages, 58 illustrations. D. Appleton & Co., New York, 1906. (Full notice next month.)

The World's Anatomists. By G. W. H. Kemper, M. D. With 11 illustrations. P. Blakiston's Son & Co., Philadelphia.

## Reports

The State Committee on Venereal Prophylaxis arranged for a public meeting, under the auspices of the Wayne County Medical Society, on December 9, 1905. About 250 invitations were sent to prominent Detroit clergymen, members of the bar, educators, and business men. The meeting, held in the auditorium of the Museum of Art, was well attended and much interest was shown in the subject.

A number of short papers were read by the members of the profession. Dr. W. J. Herdman, of Ann Arbor, spoke on "**Nervous Affections Due to Venereal Diseases.**"

Both syphilis and gonorrhea cause diseases peculiar to the nervous system, but the latter of the two is under such a heavy indictment for the ravages it causes in other important organs and functions of the human body, that the injury it occasions in a direct manner, to the nervous system shrinks into comparative insignificance.

With syphilis the case is very different, for while its destructive action is by no means confined to the nervous system this is nevertheless a favorite territory for its invasions. It enters this important domain by several pathways and its invasions are always attended by most disastrous consequences. The nature of this enemy is such that no part nor function of this ruling tissue escapes; no age is respected.

*No Age Exempt from Syphilis.*—From the very beginnings of life in the child yet unborn, to the time when, by reason of age, the material body is laid aside, this enemy lies in wait to destroy it. When once it gains a lodgement within the body it either directly instills its subtle poison into and weakens or destroys those delicate cells upon which the highest functions of both body and mind depend; or it effects the same result, indirectly, by obstructing the blood and lymph channels along which the nourishment, essential to these cells, is conveyed.

In one or other of these ways many a child is blasted while still in the womb, and if born to

separate existence, it enters upon its life with a deformed and enfeebled body.

*Effects of Heredity.*—A large share of the great host of idiots, imbeciles and feeble minded, innocent incompetent, burdens to themselves, their families, to society and the state, are such by reason of syphilis.

To the same cause may be traced, in numerous instances, the lack of that developmental force which accounts for the imperfect eyes, ears or limbs, hearts, lungs and other important organs, which so many children receive as a part of their inheritance.

If perchance one escapes the dire effects of the prenatal ravages of this most potent virus, he or she is by no means safe at any period of later life from possible infection, for, as is well known, it needs but to gain access, by whatsoever channel, to the blood, the tissues and organs of the body for its work of destruction to begin.

*The Innocent Victims.*—Neither syphilis nor gonorrhea are, of necessity, diseases of venereal origin. This is, perhaps, the doorway by which their *materias morbi* gets access to the body most frequently, yet as long as the present ignorance, misinformation and indifference as to their capacity for evil exist, and barriers of defence against them are not raised, there are many avenues left open by which they may invade the bodies of the innocent.

Having once passed the portals of the body, the virus of syphilis attacks the nervous system most commonly by producing changes in the blood-vessels. No structure of the body is so dependent as the nervous tissue upon an abundant and uniform supply of blood. Every sensory, motor and mental function finds this indispensable to its action.

*First Mode of Invasion (Arteritis).*—The syphilitic virus excites a morbid cellular action which threatens the walls of the arteries of the brain, of the spinal cord and of the nerves. The currents of blood are disordered, obstructed, cut off. In consequence, nerve functions are deranged, weakened, paralyzed, often permanently destroyed. To this manner of invasion and the dire effects that flow from it, there is scarcely any limitation as to place and degree, except that the brain, having the largest mass and consequently the most necessity for abundant blood supply, suffers most. The hearing, the sight, the sensations of feeling or some of the important movements of the body, all depending upon the integrity of the nervous system, are likely to suffer. Defects both mental and physical of infinite variety result; functional, structural, varying in de-

gree and permanency in proportion to the locality and the extent to which the blood supply is cut off.

**Second Mode of Attack (Meningitis)**—A second mode of attack and one equally destructive, though somewhat less frequent than that just described, is inflammation of the membranes which surround the brain and cord, supporting them and carrying the blood-vessels and lymphatics that supply them (meningitis).

The products of this inflammation, like the changes in the blood-vessels, clog the pathways for nutrition, rob the nerve cells of their supply of food, irritate and compress them; and the parts thus damaged never fully recover, though prompt and appropriate treatment may remove some of the more prominent symptoms.

**Third Mode of Attack (Gumma)**—As a third mode of attack the specific inflammation due to this virus heaps up the products of its action in nodules and masses of new growth (gumma), which by crowding upon and compressing the delicate nerve tissue at one or another point, give to the disease the symptoms and effects of tumors, which always result in damage to the nervous tissue in greater or less degree, no matter what the treatment employed.

**Fourth Mode of Attack (Degeneration)**—But it is not only by these indirect modes of attack upon the nervous system that syphilis is so formidable an enemy to this as to other tissues of the body. In some less demonstrable but as surely causative manner it operates to reduce directly the vitality and resisting power of the nerve cells, so that they are prone to degenerate. Locomotor ataxia and parietic dementia, two of the most prevalent and intractable diseases of the nervous system at the present day, diseases involving both brain and cord and undermining their noblest functions, are now tracable to syphilis; and while this cannot be said, as yet, to be the sole cause of these degenerative diseases, it is generally conceded to be the chief factor in the production of from 70 to 80 per cent of them.

Nor is it the nerve tissue alone that is made to feel this weakening effect and is rendered less resisting to other hostile agents through the poisoning action of syphilis. The tissues of all important organs are either directly, or by reason of their lack of nervous energy, likewise enfeebled. The ravages of syphilis may break down the defences of the organism so that it is made a prey to other agents of disease.

**Weakens the Body as a Whole**—At a recent meeting of the National Association for the Study and Prevention of Tuberculosis, Dr. Abram

Jacobi, the eminent specialist, said in the course of his remarks on the causes of tuberculosis in children, "when in a family we see child after child show signs of tuberculosis, it is well to look for syphilis in the mother."

Thus this scourge, which we, as physicians, know to be largely preventable, if rationally dealt with in its incipient stages, is devastating humanity in the very strongholds of its highest civilization, and in ways most vital to its upward progress.

It will require all the forces that can be mustered by an enlightened and awakened intelligence, physical, social, educational, legal and moral, to co-operate for its suppression and overthrow. The burden has long been too great for the members of the medical profession to bear alone. The times seem ripe for a concerted and effective action on the part of all who wish their fellows well and are willing to work for that end.

Dr. C. B. Burr, of Flint, discussed "**Cost to the State of Patients Who Are in Our Asylums as the Result of Venereal Disease.**" (See *Detroit Medical Journal*, January, 1906.)

Dr. H. O. Walker's paper was on "**Venereal Affections as Seen in Surgery.**"

"**Venereal Affections as Seen in Ophthalmology,**" was discussed by Dr. Flemming Carrow. (See *Detroit Medical Journal*, January, 1906.)

"**Venereal Affections as Seen in Otology,**" was Dr. Emil Amberg's subject.

**Abstract**—Syphilis can affect any of the three parts of the ear.

The syphilitic affections of the outer and middle ear are not different in their nature from syphilitic affections of other parts of the body, but on account of their location they may lessen the efficiency of the same. Bruekner found that five per cent of middle ear suppurations were caused by syphilis. Wilson speaks of three children in a syphilitic family in whom, soon after birth, abscesses formed in both middle ears. Antisyphilitic treatment cured them. Baratoux has found that among 43 children born syphilitic and who lived to an age from a few hours to an age of four years, the drum cavity was affected 27 times. Also the mastoid process can be affected by syphilis as well as the eustachian tube. Syphilis can close up the eustachian tube and cause deafness, because the channel, on which the middle ear relies for the sustenance of the proper balance of air pressure, is put out of order. Besides, through this tube, suppurative processes can be transmitted from the throat, which is frequently affected in syphilis.

*The inner ear.* Diseases of the inner ear occur in consequence of acquired and inherited syphilis. According to Bruekner, seven per cent of nervous deafness are cause by syphilis. Dizziness, hardness of hearing and annoying subjective noises can accompany these disturbances. Baratoux found, in his 43 syphilitic children, the inner ear four times affected.

Gradenigo found among 1,404 cases of inner ear affections, 98 caused by acquired or inherited syphilis. Hereditary syphilis can cause deaf-mutism.

It has been observed that the ear of an offspring has shown signs of grave affliction even 28 years after birth.

We learn of the very sad fact that nature not only punishes the party who acquired syphilis by diminishing the function of vital organs and by endangering health and life, but that its cruel hand makes the innocent child suffer.

## VENEREAL AFFECTIONS AS SEEN IN PEDIATRICS.

DR. CHARLES GODWIN JENNINGS.

The incidence of venereal diseases in infancy and childhood has a side more pathetic than at any other period of life. Not only is the unfortunate child innocent, but the disease is inherited or acquired from a mother usually as innocent as her offspring and as ignorant of the cause of her condition.

The disastrous effects of inherited syphilis upon infant- and child-life are fairly well known and appreciated. While acquired syphilis in the adult is rarely immediately dangerous to life, the mortality of inherited syphilis is very high. In the active developmental period of intra-uterine and infant life the delicate organs and tissues form a most favorable soil for the activity and growth of the syphilitic virus.

Of 1,700 syphilitic pregnancies recorded by Hyde, one-third resulted in the death of the fetus before the termination of gestation. Of 2,038 syphilitic children in the foundling hospital of Moscow, over 70 per cent died. Of 1,121 syphilitic births observed by Hyde in America, 916 died within the first year.

Syphilis is conveyed to the ovum, (1) by the sperm cells of the father; (2) by the tissues of the mother; (3) from both parents. It is possible for the father to beget a syphilitic child and the mother escape infection. A child more often inherits the disease from its mother than from its father.

While the tendency is for the disease to disap-

pear in time, it may take years to do so. Syphilitic children have been born to syphilitic parents 20 years after the primary infection. In the life history of the disease there are periods of activity and periods of quiescence. Children conceived during periods of activity are syphilitic, while those born during periods of quiescence may be healthy.

The effect of syphilis is to kill the embryo, if the disease of the parents be sufficiently virulent, a condition which depends to a great extent upon the length of time that has elapsed since infection. The maternal history shows repeated abortions until finally, when the virulence of the disease has diminished, a living child is born.

Infants showing symptoms of syphilis at birth or a few days after, usually die before the end of the first year. Many with a less virulent infection may be saved by breast feeding, favorable hygienic surroundings and prompt and efficient medical care.

A certain number of children, apparently healthy at birth and during infancy, develop in childhood or early adolescence the various pathological manifestations of late syphilis. Thus the deformed Hutchinson teeth may mark the syphilitic taint through life. A syphilitic inflammation of the eyes may hamper the whole period of childhood and adolescence and leave a more or less serious permanent impairment of vision.

Deeply seated ulcerations and chronic visceral inflammations may render a child a chronic invalid and a burden to society.

Destructive syphilitic lesions of the bones and extremities may leave him a dependent cripple.

Thus, while the future of the offspring of syphilitic parents may justly cause apprehension, it must be recognized and taught that the outlook is not altogether a dark one.

A syphilitic father will not necessarily produce a syphilitic child nor will a syphilitic infant follow with certainty even if both father and mother be syphilitic. Medical surveillance and treatment during the fertile period of married life will reduce the chances of diseased offspring to a minimum and enable syphilitic parents to bear and rear a healthy family.

It is not probable that syphilis is transmitted to the third generation. The syphilis of the present time is not the terrible malady it was when it first infected Europe. The general infection of the race and the transmission of the disease through countless human beings has attenuated the virus and conferred a limited immunity upon those now living.

Only in the last few years has the far reaching

influence of gonorrheal infection upon infants and children been appreciated in the medical profession. At the present time it is little known to those outside, that a light attack of gonorrhea is often as dangerous to child life as its feared and respected relative, syphilis.

The discovery of the specific organism of gonorrhea has enabled investigators to identify and remove pathological conditions and to trace them to the primary venereal infection.

Ophthalmia neonatorum is usually a gonorrheal inflammation of the eyes, infection taking place at birth from a mother ignorant of her condition. Nearly 11 per cent of the blind owe their misfortune to an ophthalmia neonatorum.

Subsequent to birth, girls suffer from gonorrheal infection much more frequently than boys and, in them late disastrous effects are more common.

Among the children of the poor and uncleanly, and in institutions, gonorrheal vaginitis is a common disease. In households the infection is carried from the older members of the family by uncleanly habits. The entrance of a child with gonorrheal vaginitis into an institution is often the beginning of an epidemic that spares none of the female inmates.

While it is not often that the immediate effects of the disease are dangerous to life, the remote effects are of the most serious character.

Invasion of the uterus is usual in all severe cases of specific vaginitis in infants and children and extension into the fallopian tubes is not uncommon. These pelvic inflammations may lay the foundation of a chronic invalidism and may in after life be a serious impediment to marriage and maternity.

Extension of the inflammation to the peritoneum, bladder or kidneys, gonococcus septicaemia, and invasion of the heart and joints may immediately threaten life or result in prolonged grave illness or permanent impairment of health.

In the few moments allowed it is not possible to more than mention some of the disasters to their innocent offspring that may come from the indiscretions of parents, but enough can be said to bring emphatically to their minds the necessity of earnest public and private efforts to control the spread of venereal infections.

#### VENEREAL AFFECTIONS AS SEEN IN GYNÉCOLOGY.

DR. J. H. CARSTENS.

The gynecologist quite often sees venereal diseases and their sequelæ. I will only refer to gonorrheal affections.

When a man marries and is affected with a venereal disease which he thinks is cured, but it is not, he very often gives it to his wife, during the first few days of married life. If promptly and energetically treated it might be controlled, but only too often it is not recognized or not vigorously treated and the result is extension of the disease to the womb and fallopian tubes, where inflammations of the ovaries and in the pelvis are started. These seldom subside, but often end in chronic invalidism and we may say, invariably, sterility. Sometimes the woman acquires the disease from her husband after she has been sick a long time, or when he and she have been separated, and the result is the same. That eminent English abdominal surgeon, Lawson Tate, was very emphatic and claimed that nearly all pelvic diseases of women, tumors included, were caused by gonorrheal infection, but this is shown to be a mistake. Diseases of the tubes and ovaries may be caused by other germs than the gonococcus, and in Germany where they have large hospitals and where they have patients under perfect control, it has been proven by a most searching investigation that only 50 to 55 per cent of pelvic and tubal abscesses or inflammations are due to venereal affections. Tumors are not caused by venereal diseases.

I want to also call attention to the fact that many women get this disease very innocently. I have known in my own experience of quite a few ladies getting gonorrhea by having their affected servants use the syringe of the madam. I raise this point simply to show how very careful a woman must be.

Knowing from a large experience that many of the inflammatory diseases of the female pelvic organs and the resulting sterility, are caused by venereal affections, I have been a strong advocate of controlling and preventing this disease, as much as possible. In order to do this I would suggest:

1. A most thorough education of the public in reference to the signs and symptoms, the danger of, and need of vigorous *treatment* of this disease.
2. A most careful investigation by physicians of every *suspected* case. Any case found to be gonorrheal should be subject to the most vigorous and continued treatment, until the disease is absolutely cured.
3. All professional and semi-professional prostitutes affected with the disease should be immediately sent to a hospital and kept there until cured.



## VENEREAL AFFECTIONS AS SEEN IN DERMATOLOGY.

DR. ALBERT E. CARRIER.

Covering the whole body, the skin furnishes an enormous surface for the development of sores of any kind, and when the sores are destructive in nature, they eat through the whole thickness of the skin, and the resulting scar is very disfiguring.

There are two venereal diseases that affect the skin, namely, "syphilis" and "chancroid."

Chancroid is a local disease which at the beginning is a small sore not larger than the head of a pin, but which grows rapidly, forming a large ulcerative sore that destroys the skin. There may be only one sore at first, or there may be several. The amount of tissue these sores may destroy will be realized when a single sore is often six inches in diameter, and as the sores may come upon any part of the body it is easily seen what a disfigurement would occur if it was on the face. The matter from the chancroidal sore is very contagious, and if it comes in contact with the skin will be very apt to cause other sores, and it is necessary to exercise great care to prevent this matter from coming in contact with the healthy skin. The lymphatic glands that are connected with the skin where a sore breaks out, become affected, swell up sometimes as large as a hen's egg, are very painful, and when matter forms in them, an enormous amount of tissue is destroyed, forming large abscesses which do not tend to get well, but spread by attacking new glands, and requiring a severe surgical operation for the removal of every particle of diseased tissue before a cure results. There is always danger that blood poisoning will occur. While this disease is local at the beginning, and may have only one little sore, it is always attended with the danger of affecting the lymphatic glands, and of its resulting in blood poisoning, and when recovery takes place the site of the sore is always marked by a very disfiguring scar that remains through life.

*Syphilis*—Syphilis furnishes about 12 per cent of all the cases that come to the physician who confines his practice to the treatment of skin diseases. Syphilis is a very common disease, and five per cent of all cases are contracted innocently; it is a disease that extends over a period of years and during all this time eruptions are liable to occur in the skin. This disease is contagious for three or four years and may be transmitted by inheritance to children from either the father or the mother during all this time. The disease commences as a single sore which de-

velops at the point where the poison entered the surface, and which may be so small as to escape notice entirely. Another fact which renders it liable to escape notice lies in its not being painful, nor does it itch, or burn. After a few weeks, however, the syphilitic has an eruption, which may first be discovered after taking a hot bath, or after severe exercise. The eruption shows first on parts of the body that are covered by the clothing. The eruptions, rashes, or sores that are found in syphilis differ with the age of the disease, attacking the superficial portion of the skin at first, and as the disease grows older attacking the deeper portions. The first rash is a red, or brownish red in color, showing on covered parts of the body. It is made up of spots separated from each other by healthy skin and not giving any uneasy sensations whatever. The eruptions of syphilis may simulate that of any other skin disease and it is a difficult matter to tell whether an individual has syphilis or not by the eruption only, and herein lies a great danger, for the disease can be caught from the rashes at any time during the first three or four years of the disease.

With the first sore we have enlarged glands, just under the skin but they are not tender nor do they ulcerate. The eruptions that follow the first rash are large, or small pimples that are reddish brown in color, may be small as a pin-head or large as a bean, and may appear on the face as well as other parts of the body; with the pimples we may have little boils, and when these break and dry up small pits like those of small pox will remain during life. Later in the disease, the sores are larger, deeper seated in the skin, and show little tendency to heal, forming ulcers that are covered with a thick, dark colored crust, occurring on any part of the body and when the sores are numerous, giving a very disfiguring, and disgusting appearance. If these sores happen to break out on the nose, or on the ear, or on the eyelid they may destroy these parts entirely. When located upon parts that are near bones, as on the head for instance, the ulcer eating through the skin will finally destroy the bone also. Words are inadequate to describe the results of these sores on the skin. Some of the sores of syphilis develop on the inside of the lips, on the tonsils, the inside of the cheeks, and on other mucous surfaces, and the disease is conveyed by them just the same as it is from the sores on the skin. When inside the mouth the sores often destroy both the hard, and the soft palate, and the back part of the nose. At their worst these sores beggar description. Direct

contact with a person suffering from syphilis is not necessary to contract the disease, it is caught by drinking cups, razors, pipes, combs, brushes, hats, bed linen, clothing, that have been used by a person who has the disease. This danger is not sufficiently realized by the people.

When the disease is inherited, the eruptions on the body are just the same as if the disease was caught in the ordinary way and are just as contagious. From the fact that nearly all syphilitic eruptions give no discomfort, no itching, smarting nor pain calling attention to them, they are often passed by as of little moment, and as the eruptions look like those found in other diseases, we are apt to forget the danger of contracting syphilis from them. To avoid this danger it would be better to regard all skin diseases as dangerous, and to take pains not to come in contact with them. Kissing is the cause of one-quarter of all cases of syphilis that are acquired innocently.

The following abstract of the **Michigan Marriage Law** was prepared for the meeting by Attorney George B. Yerkes:

Any person who has been afflicted of syphilis or gonorrhea and has not been cured of the same, who shall marry, shall be deemed guilty of a felony and upon conviction thereof in any court of competent jurisdiction, shall be punished by a fine of not less than five hundred dollars nor more than one thousand dollars, or imprisonment in the State prison at Jackson not more than five years, or both such fine and imprisonment in the discretion of the courts;

Provided, that in all prosecutions under this act a husband shall be examined as a witness against his wife and a wife shall be examined as a witness against her husband, whether such husband or wife consent or not. And provided further, that in all cases arising under this act any physician who has attended or prescribed for any husband or wife for either of the diseases above mentioned shall be compelled to testify to any facts found by him from such attendance.

The discussion was opened by Dr. Denslow Lewis, of Chicago, who said, in part:

The kindly introduction of your president justifies my presence. I trust I may be considered one of your number, for I am a graduate of the departments of pharmacy and medicine of your great university.

The cause of humanity appeals to all. The great work in which you are engaged is very near my heart. In season and out of season I have insisted for many years past that sex relationship should be understood and that the danger of ven-

ereal infection should be made manifest to the young, so that this infection might be avoided. I frankly confess I could not forego the pleasure of being with you tonight, for your meeting is the first of its kind ever held in America; it marks a new epoch in philanthropic prophylaxis and is, in effect, the birth of a new era in professional endeavor. This society may justly claim the honor of having taken the initiative in a movement which I believe is destined to extend throughout the country and to be productive of vast good.

Professional opinion has changed within the past few years. In Germany, France, Italy, Spain, Holland, and now in our own country societies have been organized for the study of the best means of every kind—moral, legislative, social, as well as medical—to be employed in the prophylaxis of these diseases. When the American Society of Moral and Social Prophylaxis was born on February 9, 1905, the president, Dr. Prince A. Morrow of New York, said: "A free discussion is, of course, an essential preliminary to any well-considered action, especially when such action proposes to deal with what is confessedly the most difficult of all the problems of social hygiene." This is the proposition I have always maintained and the only one for which I have fought. Free speech must be encouraged; free thought must be stimulated. Papers read in medical societies are of value, but our chief endeavor should be to reach the public, especially the young, and to diffuse the knowledge we already have. In the furtherance of these praiseworthy efforts this meeting to-night will, I know, produce definite results. It will serve as an incentive to other communities throughout the country. You have taken the first step and your example will be followed. The public must be taught the dangers of the venereal plague. I am overjoyed at the success of this meeting. Personally, professionally and officially, I express to you my sincere appreciation and I tender you my heartfelt thanks.

Forceful speeches were made by Dean Hutchins and Dr. Vaughan of Ann Arbor, Rev. A. H. Barr, Rev. L. S. McCollester, Rev. C. L. Arnold, Rabbi Franklin, Rev. S. S. Marquis and Principal Frederick Bliss of the Detroit University School.

Dr. Herdman moved that, "A committee of six be appointed by the chair, of which committee the chairman of this meeting shall be a member, to take steps for a permanent organization in this state for the suppression and eradication by all proper means, educational, sanitary and legal, of the diseases caused by syphilis and gonorrhea."

"It shall be the province of this committee to

enlarge its membership to twenty, by the election of representative men and women from various parts of the state. Such committee, so enlarged, shall constitute a permanent committee on organization."

A few days after the meeting, the chairman announced the committee of six as follows:

Rev. A. H. Barr, Detroit.

Prof. Frederick Bliss, Detroit.

Dean Hutchins, Ann Arbor.

Dr. W. J. Herdman, Ann Arbor.

Dr. A. P. Biddle, Detroit.

#### Report of the Amalgamation of Kalamazoo, Van Buren and Allegan County Societies.

At the annual meeting of the Kalamazoo Academy of Medicine a movement was inaugurated for the consolidation of the county societies of Kalamazoo, Van Buren and Allegan counties with the Kalamazoo Academy of Medicine, the reorganized society to be known as the "Kalamazoo Academy of Medicine (Kalamazoo, Van Buren and Allegan Counties)." It was necessary to retain the name Kalamazoo Academy of Medicine that our title to our splendid rooms in the Public Library might not be vitiated.

Amendments to the constitution and by-laws of the academy were presented (and adopted at the February meeting) to conform with the constitution and by-laws of the State Medical Society. The county societies of Kalamazoo, Van Buren and Allegan counties having voted to surrender their charters and unite with the Kalamazoo Academy of Medicine, were merged with the academy. All members of each society who were not already members of the academy were admitted upon personal application of each member in the usual way.

The Kalamazoo Academy of Medicine now has a membership of 82, of whom 73 have paid their state dues. This number includes 12 members who had paid their dues through the Van Buren county society just before uniting with the academy.

The academy has a regular monthly meeting occurring on the second Tuesday of each month. The next annual meeting will be held in December.

At the last annual meeting, the following officers were elected: Dr. A. H. Rockwell, Kalamazoo, president; Dr. N. A. Williams, Bangor, first vice-pres.; Dr. O. F. Burroughs, Jr., Plainwell, second vice-pres.; Dr. Walter den Blyker, Kalamazoo, secy-treas.; Dr. E. H. Van Deusen, librarian.

Board of Censors, 1906—Drs. G. D. Carnes, South Haven; R. E. Balch, Kalamazoo; O. H. Clark, Kalamazoo; H. B. Osborn, Kalamazoo; O. F. Burroughs, Jr., Plainwell; E. P. Wilbur, Kalamazoo.

Drs. F. A. Welsh and A. W. Crane have been elected delegates to the state meeting. Drs. O. F. Burroughs and Walter den Blyker, alternate.

WALTER DEN BLYKER, Secy.

### County Society News.

#### CALHOUN.

The first quarterly meeting for 1906 was held at Battle Creek on March 6, at 2 p. m. The following program was carried out:

"Breast Tumors in Young Women," Wm. A. Spitzley, Detroit, Mich.

"Ear Conditions of Practical Importance to the Family Doctor," Edw. J. Bernstein, Kalamazoo, Mich.

"A Few Electric and X-Ray Cases," Eugene Miller, Battle Creek, Mich.

A. S. KIMBALL, Sec'y.

#### GRAND TRAVERSE.

At the annual meeting the following officers were elected:

A. H. Holiday, M. D.,—President.

I. A. Thompson, M. D.,—Vice-President.

J. W. Gauntlett, M. D.,—Secretary.

O. E. Chase, M. D.,—Treasurer.

J. W. GAUNTLETT, Sec'y.

#### JACKSON.

The afternoon session of the March meeting was given up to a discussion of obstetrical papers. In the evening, John F. Herrigan, city attorney of Jackson, read a paper on "The Physician as a Defendant."

This was the beginning of a series of lectures on medico-legal subjects to be given by prominent lawyers of the city.

R. GRACE HENDRICK, Sec'y.

#### LENAWEE.

At the quarterly meeting of the society, held February 13, 1906, the following paper was presented: "From Graduation to Practice," by M. B. Prentiss, M. D.

The graduate in medicine, in beginning the practice of his chosen profession directly after receiving his diploma, finds himself not unlike

the newly arrived traveler in a foreign country. The chances are that the stranger's sole knowledge of the foreign tongue has been acquired at home. By a competent teacher and studious work, in the hands of his own masters, he thought himself quite proficient; but abroad, the inhabitants speak their language in a different way. They have other voices, their expressions are peculiar, they make strange gestures and utter their words so rapidly, the result is that while the bewildered stranger catches here and there a familiar word or a simple phrase, his diagnosis of the general meaning of what is said is apt to be very vague and confused.

The plight of the young physician is not much better. His mind is stored with excellent medical precepts, together with a fine assortment of correct prescriptions. He can discourse to his patient right learnedly, but, like the traveler, he can talk better than he can understand. In his mental outfit are the keys to the diagnosis of numberless diseases, but for the particular case in hand none of them seems to fit. He recognizes, as familiar, certain features, certain symptoms, but then there are others which are certainly out of place.

The art of medical observation and of appreciating symptoms at their proper value has not been acquired, or, in other words, the young graduate lacks practical experience. His four years' college course has afforded him more instruction than training. What I believe the young graduate wants more than his text books and notes to lead him in the beginning of practice is some of his own good, sound sense, together with the advice of some professional friend who has had years of experience in actual practice.

The graduate of today certainly is better qualified than was the graduate of twenty or thirty years ago, by reason of a more thorough and extended college course, but add to the graduate of today the experience of the medical man of twenty or thirty years of practice and you could truly say: "Knowledge is power, when conjoined with wisdom." The training of practical observation and experience is necessary before his knowledge can profit him. After he has obtained that which he much needs—a few years of practical experience—has had a taste of the hardships of professional life, has experienced the irregularities of living, has come to the realization that instead of a life of ease and pleasure that the practice of medicine amounts to actual toil, and after he has experienced some of the bitter and the sweet of the professional life, then he is

truly fitted to continue his way on to the road of fame.

At no period in our professional life, to my mind, is it better than that at this period, to devote a little more time and add a little more capital to our mental purse by taking a post-graduate course in some of our large cities. Today there are excellent opportunities in this country for the pursuit of such studies as are demanded at this period of the medical education. In New York and other cities, there are post-graduate schools and polyclinics, where courses are especially designed for the profession—courses of short duration, several of which could be pursued together, and in which the matriculant is brought in contact with an abundance of classified material, which he is able to study under the guidance of experienced specialists. The profession is beginning to realize the advantage of these post-graduate schools, and not only the young graduate but many of the older members of the profession are taking advantage of the wonderful opportunities they offer for the study of the art of medicine and surgery in all its branches. In my own experience in my course in New York a year ago, fully one-half of the doctors there attending, were members of the profession many years ago. I believe the post-graduate schools are very essential, not only to our mental but to our financial purse as well.

The doctor who practices with an eye singly to his fee is false to his oath and false to his patient. In the early studies of the young physician, the commercial spirit is quite apt to predominate. The desire to prosper is a legitimate incentive. The greater the interest in his work the more likely that it will be effective and fruitful, but the prevailing motive should be the desire to acquire competence in his art. Fill well the mental purse and it will be seen how commercial aims may coincide with the legitimate requirements of science. The most productive work is always that which is directed to ends in which the mind takes an absorbing interest.

The interest of the medical man may be added to by judicious attention to his natural inclinations in any particular department of study. After the fundamental part of his medical education is completed, the physician soon finds his natural aptitudes tending towards certain special lines of study. By properly heeding these intimations, he will not only add a spark of enthusiasm to his study, but by giving his work more definite direction, he will improve his quality. The attempt to cover the whole field of medicine uniformly will result in uncovering his weak points.



The aim should be, while striving to acquire proficiency in all departments, to attain excellency in one. We have men in the profession to whom "specialist" justly applies, but the specialist has no true title to the name who is not first a good physician. It is not my intention to advise every doctor to become a specialist, but what I would urge is that each choose, sooner or later, some particular line of study in which he shall aim at an especially high standard of excellence, and from a good point of departure he can better attack the whole field. I do not mean that other departments of study shall be neglected, but that at some point there shall be a glow in his work, and the fire of enthusiasm once kindled will soon inflame the whole field of medicine and would have a tendency to keep us studious and better fit us for our life work.

#### MONROE.

The regular quarterly session of this society was held January 18, 1906, in Newport, at the residence of Dr. Jerome Valade. The meeting was well attended and the proceedings interesting, practical and profitable.

Dr. P. S. Root read a paper on "Peritonitis," which brought out a very general discussion.

Dr. C. T. Southworth read a paper on the "Care of Scalp After Continued Illness," and Dr. Valade reported two cases from his practice; one a case of "Herpes," the other, a case of "Foreign Body in the Alimentary Canal."

Dr. Jerome Valade was elected delegate to the state meeting, and Dr. C. T. Southworth, alternate.

Next meeting in Monroe, the third Thursday in April.

After the session, the members were banqueted by Dr. and Mrs. Valade, the *piece de resistance* being the celebrated Monroe county muskrat. These toothsome little animals had been raised and fattened on the doctor's own private preserve, and were served, both boiled and fried, to the king's taste. A hearty vote of thanks was tendered the host and hostess for the entertainment.

GEORGE F. HEATH, Sec'y.

#### Muskegon-Oceana.

The regular meeting of the Muskegon-Oceana Counties Medical Society was held at the office of Dr. J. F. Dendow, Muskegon, in the evening of March 3, 1906.

Dr. Gayfree Ellison gave a very instructive talk on the condition of medical service in the Philip-

pine Island campaign, as seen from the standpoint of a private in the ranks. Dr. Ellison was with the Kansas volunteers before obtaining his degree of M. D.

Dr. John Vander Laan, senior member of the board of directors, was not present, owing to his having recently passed through a severe attack of pneumonia, which happily was aborted. The doctor is now convalescent and a resolution of sympathy for him in his illness and pleasure at its danger being apparently passed, was unanimously adopted.

Dr. W. L. Griffin, of Shelby, Oceana County, was elected delegate for 1906.

Dr. Jacob Oosting, of Muskegon, was elected alternate delegate.

Dr. Griffin invited the society to hold its regular meeting at his home at Shelby, Oceana County. This invitation was unanimously accepted and date of meeting placed at June 8.

General discussion and adjournment.

V. A. CHAPMAN, Sec'y.

#### OSCEOLA-LAKE.

The annual meeting was held at Reed City January 10, 1906. The following officers were elected:

President—A. Holm, Ashton.

Vice-President—D. S. Fleischauer, Reed City.

Secretary and Treasurer—T. F. Bray, Reed City.

Delegate to State Society—H. L. Foster, Reed City.

Alternate—G. F. Fields, Chase.

THOS. F. BRAY, Sec'y.

#### O. M., C. O., R. O.

The O. M., C. O., R. O. County Medical Society held its regular meeting Feb 21, at Grayling.

The meeting was largely attended and the enthusiasm ran high.

Dr. John McLurg, of Bay City, presented a very able and interesting paper on "Typhoid Fever," which created a new interest in the diagnosis and treatment of that disease.

Dr. McLurg was tendered a vote of thanks for the courtesy which he extended to this society.

Dr. Stanley N. Insley, ex-president of the society, tendered a banquet at the close of the meeting and all present pronounced it as one of the best meetings, both scientifically and socially, in the history of the society.

CLIFFORD C. CURNALIA, Sec'y.

**Shiawasse.**

The regular monthly meeting of the society, held in the city of Owosso, March 6, was attended by about 15 members.

Dr. Joseph E. Marshall, of Durand, was elected to membership.

The plan of holding the meetings at the various towns of the county was discussed and left to the discretion of the officers of the society.

A judicial committee was appointed by the president to obtain an opinion from an attorney in reference to fees allowed by poor commissions for indigent surgical services.

The subject of "A County Fee Bill" was discussed by the members of the society and a committee consisting of one doctor from each town was appointed to confer with their fellow practitioners and obtain their opinion in regard to such a fee bill.

Dr. Edwin Elliott, of Chesaning, gave an interesting and instructive discussion on "A Review of a Year's Practice."

JAMES A. ROWLEY, Sec'y.

**WAYNE.**

General meeting, February 5, 1906. Dr. J. A. MacMillan read a paper: "**Colostomy in the Treatment of Cancer and Other Grave Lesions of the Rectum.**"

Recent statistics show that a mortality of about 25% follows extirpation of the rectum for cancer or other disease. Investigation of this high death rate demonstrated that the chief etiologic factor is sepsis. More than 50% can be traced directly to infection. My experience in these cases confirms what is now being advocated, that a preliminary colostomy is the only effectual way of diminishing the mortality from this cause. The colostomy should be performed a week or more before the extirpation. Several advantages are obtained from this procedure:

(1) The field of operation can be rendered nearly aseptic, before the radical operation is performed. This is attained by the absence of feces from the rectum and by daily irrigation with antiseptic solutions.

(2) From the time the artificial anus begins to perform its function the rectum receives the benefit of physiologic rest. The benefits from this factor must be seen to be appreciated.

(3) Should the disease be other than malignant, it will become manifest by the rapid improvement which in many cases with but little other treatment goes on to complete cure.

Colostomy in these cases of operable rectal

disease is attended with very little danger. It is easily performed, and if desirable it may be performed under local anesthesia.—*Author's Abstract.*

Dr. Louis J. Hirschman read a paper: "**The Treatment of Chronic Constipation Without Cathartics.**" This paper appears in full in the current issue of the JOURNAL. The discussion of this paper and the preceding follows.

Dr. J. H. Carstens: Operation for carcinoma of the rectum is a radical cure in even less than 15 per cent; still, operation is advisable. Constipation is more a habit than anything else. Many patent medicines depend for the good they do on evacuating the bowels and thus relieving the auto-intoxication, which accounts for many ills of life. People of constipated habit should drink two quarts of fluid, water or not, and take more exercise. Occasionally due to lacerated perineum.

Dr. F. W. Robbins: Examination for the underlying cause is important in every case, and laziness in this respect in treating so-called constipation may be costly.

Dr. Charles Douglas: Certain patients cannot take two quarts of fluid in a day without great disturbance of digestion. In certain instances, warming the water will assist in making it tolerable. As colostomy gives rest to an ulcerated rectum, so regulation of the diet in children, by preventing the production of irritant feces, and gas, can be made to do the same thing.

Dr. Max Ballin: If not seen early, colostomy will not alter the value of radical operation on a malignant rectum, but certain non-malignant cases can be improved in no other way. Constipation is too serious a matter to be left to quacks and osteopaths.

Dr. P. G. Sanderson: Advised a fixed time daily for the attempt to move the bowels. In preparation for operation on the lower part of the intestines, as bacterially clean a condition as possible should be induced by reducing the amount of food, by exhibition of acetozone or some other effectual disinfectant, and by colonic flushing.

Dr. C. D. Aaron: If the constipation is spastic, not atonic, the measures mentioned are contra-indicated. Oleum-petrolatum is the remedy. Spastic constipation is manifested by a palpably tense, contracted sigmoid.

Dr. W. F. Metcalf: If earlier diagnosis were made, operation would be more commonly a radical success. In women, the lower rectum can be removed by incision through the perineum, and the continuity of the remaining gut with the anus restored.

Dr. MacMillan: Rectal carcinoma should be diagnosed early, but even in moderately advanced

cases, colostomy, besides assuring diagnosis, causes a surprising shrinkage of the disease, and thus is an excellent preparation for operation.

Dr. Hirschman: The paper was presented to show that there is a non-surgical side to proctology, and to set forth as available for the general practitioner, a nature-like effectual method of treating chronic constipation, after carefully excluding, by proctoscopy and other means, structural obstipation. This method can be practised without much exposure, and does not require the use of a proctoscope for the introduction of the pneumatic dilator, as in the older methods.

Meeting of Medical Section, February 12, 1906. Dr. T. B. Cooley read the paper: "**Treatment of Tetanus.**"

*Case Reports.*—Three cases were reported, two of which were seen in consultation. All three recovered. In the first, a very severe case following blank cartridge wound, after a week of treatment, including daily curretting of the shallow wound, without improvement, further exploration revealed very minute fragments of stocking in apparently healthy tissue below base of wound. Recovery followed their removal. The third, a case of multiple gunshot wounds of the leg, was used as an illustration of the occasional necessity for amputation. Antitoxin (240-300 c. c.) was used in all three cases, but was not apparently an important factor.

*Etiology and Bacteriology.*—Nothing new under these heads.

*Pathology.*—The work of Gumprecht, Marie and Morax, and Meyer and Ransom, and the recent contradictory work of Zuprick, were reviewed briefly, with the conclusion that neither theory was sufficiently demonstrated, and the whole ground must be gone over again.

*Symptoms and Diagnosis.*—Diagnosis is frequently not made early enough, because physicians do not have the possibility of tetanus clearly enough in mind.

*Prognosis* was discussed at length, with some analysis of existing statistics, and following conclusions drawn:

1. Antitoxin has not reduced the mortality so much as has been claimed.
2. The so-called "idiopathic" cases are the most favorable, while the "Fourth of July" form is always grave.
3. The rapidity of development of symptoms after their appearance is a better guide to prognosis than the incubation period.
4. Early diagnosis and treatment affect prognosis favorably.
5. Under intelligent treatment mortality should not average over 40%—probably less.

*Prophylaxis.*—Methods well known, but not commonly enough practiced. Prophylactic injections of antitoxin imperative in all blank cartridge wounds—all others where infection is particularly likely.

*Treatment.*—General indications:

1. To remove infection.
2. To neutralize toxin.
3. To break up cell-toxin combination.
4. To keep patient alive.

1. *The Wound.*—Remove foreign matter and unhealthy tissue. Give air free access. Use non-caustic disinfectants. When there is doubt as to possibility of removing infection from wounds, amputate.

2. *The Use of Antitoxin.*—When given intravenously or subcutaneously it will neutralize circulating toxin. If Meyer and Ransom are right, injections into motor nerves and lumbar cord are rational, but cannot do all that has been claimed by them. If Zerprick is right, they are irrational. Injections into upper dorsal and cervical cord for relief of urgent symptoms are not irrational, but their value is not proved. Liberal doses should be used in any method.

3. *Other Special Methods.*—

*Bacell's Carbolic Acid Treatment.*—Remarkable results reported from Italy not observed in America. Treatment deserves thorough trial.

*Matthews' "Cell Catharsis."*—Such a process very desirable in tetanus. No statistics of practical results. These two methods might be combined.

*Murphy's Morphin-Eucain Injections.*—The most rational recent proposal for control of spasm. Recommended as routine treatment.

4. *Symptomatic Treatment.*—Still the most important part of treatment. Failure to meet indications promptly frequently results in death of patient. Importance of quiet, freedom from disturbance of senses.

Feeding and nursing necessity of constant watchfulness. Morphin-eucain injections, or morphin and chloral, to control spasm. Chloroform must always be at hand for emergency.

#### GENERAL CONCLUSIONS.

1. Tetanus is probably not so hopeless a disease, as we have been accustomed to suppose.
2. Prophylaxis should be more generally carried out.
3. No treatment has been proved to be specific.
4. The important points in treatment are:
  - a. Get rid of infection at once, and be satisfied with no less than absolute certainty of having done so. When in doubt, amputate.

b. Use anti-toxin freely, but don't expect too much of it, nor neglect other indications.

c. Ensure for your patient comfortable quarters, the least possible disturbance, and intelligent nursing. He must never be left alone. Control spasm by morphin-eucain injections, or morphin and chloral, but be always ready to use chloroform. Be liberal with your drugs.

5. We need accurate statistics, and all cases should be reported in full. (Author's abstract.)

Dr. E. M. Houghton: American antitetanic sera are standardized, but not uniformly. Behring's unit is the amount of antitoxin that will neutralize enough tetanus toxin to kill 40,000,000 grams weight of white mice. Sera contains from five to fifteen of these units per c. c. At a meeting of the American Bacteriological Society, December, 1905, a committee was appointed to determine a uniform standard. One grain of pure toxin from bouillon culture of tetanus is sufficient to kill a hundred men or more. Antitoxin is correspondingly potent.

Dr. David Inglis: The wound should be thoroughly opened under an anaesthetic by a surgeon. A trifling wound must be made a large one. It should be remembered that the treatment of a patient is not an experiment on antitoxin alone.

Dr. W. H. Hutchins: Culture from an engineer's hand that had been thoroughly opened surgically and soaked in one to six thousand corrosive repeatedly gave positive findings. In another case, seven cultures were made from below powder grains after death, the skin over the place in each instance being actually sterilized by cauterization; all the cultures were positive. In a third case, that was fatal from "idiopathic" tetanus, an unnoticed splinter in the toe, that had not excited any inflammation at all, gave positive culture. Magnesium sulphate injection into the cord proved successful in one case after antitoxin seemed to be failing.

Dr. C. S. Oakman: Antitoxin has proved disappointing as a curative means. Prophylaxis means surgery, by a surgeon. In a series of developed cases, none with an incubation of less than nine days recovered. About seventy per cent of pistol wounds of the palm in a series in Boston gave positive cultures, yet under prophylactic treatment in none of these did tetanus develop.

Dr. T. A. McGraw, Jr.: It was the custom in New York to search for the wad, and apply to the wound strong phenol, followed by alcohol. In a series there of suspected cases, no tetanus developed under this treatment.

Dr. H. S. Olney: Spoke of subcutaneously

feeding, by injection of 200 c. c. sterilized olive oil, in order to avoid disturbing a tetanus patient by rectal alimentation.

Dr. H. M. Rich: Spoke of a patient who died of tetanus through infection from a varicose ulcer.

Dr. Cooley: Conclusions drawn from existing statistics are probably unfair to antitoxin, because in most cases it is used in rather small amounts. Mass action is desirable, and 50 c. c. or more in a day is not excessive dosage. Given a case, all measures of treatment reasonably likely to do good should be adopted at once.

WILLIAM E. BLODGETT.

## Medical News

The government printing office has just issued a most interesting brochure of some 80 pages on the Medical and Sanitary Features of the Russo-Japanese war. It is in the form of a report by Surgeon William C. Braisted to the Surgeon General. It is worth having, and can be obtained free by writing to the Navy Department, at Washington.

The Ohio State Board of Health has decreed that all trolley and steam lines, running outside of a municipality, shall provide cuspidors for the passengers.

The British Medical Association will meet in Toronto, Ont., next August.

The new hospital at Sault Ste. Marie was formally opened on February 1st.

An Exposition of the History of Medicine in Art will take place at Berlin, on the occasion of the opening of the Kaiserin Friedrich-Haus from the end of February to the middle of April. The exhibition will comprise original paintings, copper-plates, book-plates, statues, medals, old illustrated books and manuscripts, relating to medicine, Roman and other ancient surgical instruments found in Germany, etc.

The Michigan State Board of Health has decided to issue all bulletins, pamphlets, etc., which they publish, in a uniform style, under the title "Public Health, Michigan." This will be a decided advantage in appearance and accessibility, as well as a great saving in postage.



The chair in medicine at Vienna, left vacant by the death of Professor Nothnagle, has been filled by the appointment of Van Norden, of Frankfurt.

The faculty and students of the medical department of the University of Michigan observe "Founders' Day" every year on February 22, holding exercises in one of the campus auditoriums in honor of the founders and early professors of the medical department.

This year the man selected for special honor was Dr. Moses Gunn, whose connection with the university covered a period of eighteen years. He was appointed professor of anatomy and surgery in 1849. This was the year before the opening of the medical department for students, although it had been included in the legislative act organizing the university in 1837.

From 1852 to 1854 Dr. Gunn's title was professor of surgery, and lecturer on anatomy. In the latter year he became professor of surgery, the title which he retained until his resignation from the university faculty in 1867, when he accepted the chair of surgery in Rush Medical College, Chicago. He died in Chicago, Nov. 3, 1887.

A paper on Dr. Gunn's life and work was read at the Founders' Day exercises by Dr. Charles B. de Nancrede, professor of surgery in the university. After the address a reception was held in Barbour Gymnasium.

Professor Czerny, who has held the chair of surgery in the University of Heidelberg since 1877, has resigned, in order to devote his entire time to the duties of director of the Institute of Cancer Research.

Lockhart Medical College was opened at Peking, China, on February 1st.

The directors of the Michigan Cremation Association offer a cash prize of fifty dollars (\$50) for the best essay on the subject, "Cremation as a Sanitary Reform." The essay is to contain from 2,000 to 2,500 words, must be typewritten, and sent in by July 1st, 1906. The essays will be submitted to the judgment and decision of a committee appointed by the Cremation Association. Each competitor is requested to sign his essay with a nom de plume and enclose his name in a sealed envelope, on the outside of which is also written the nom de plume. Essays and en-

quiries should be directed to the secretary of the association, Dr. Preston M. Hickey, 32 West Adams avenue, Detroit, Mich.

An international committee has been formed to solicit and receive contributions for a monument in honor of the late distinguished surgeon, Johannes von Mikulicz-Radecki, of Breslau, Germany. Drs. W. W. Keen (Philadelphia, W. S. Halstead (Baltimore), J. B. Murphy (Chicago), F. Kammerer (New York), who have been requested to serve on this committee, appeal to the surgeons of the United States and Canada for subscriptions to the fund. An opportunity is afforded not merely to testify to our esteem and affection for Professor von Mikulicz, whose memory is cherished by every surgeon of the land, but also to express our appreciation of Germany's splendid achievements in surgery and manifest our desire to strengthen the cordial relations existing between the men of science of the two countries. Contributions may be sent to any member of the committee.

### Michigan Personals

Dr. W. F. Clute, of Gladwin, was married January 13, to Miss Winnifred Tyler of the same place.

Dr. S. C. Gurney, formerly of Detroit, has entered the army as medical inspector, and has left for service in the Philippines.

Dr. Walter H. Sawyer, of Hillsdale, the new regent of the university, took his seat at the January meeting of the board.

Dr. J. A. Attridge, recently of Detroit, has removed to Lansing, where he will devote himself to surgery.

Dr. R. S. Dupont has moved from 40 Howard street to 57 Fort street west, Detroit.

Dr. J. A. McMillan, of Detroit, read a paper on "**Recto-sigmoidal Tampons in the Treatment of Chronic Constipation**," before the Chicago Medical Society, on February 4th.

Dr. Victor C. Vaughan, of the State University, announces that he will be in Detroit on Tuesday and Thursday afternoons for consultation and office practice.

Dr. and Mrs. R. A. Newman, of Detroit, have gone to Italy.

Dr. Beverly D. Harison, ex-president of the State Society, was recently tendered a banquet at the St. Claire Hotel, Detroit.

Dr. F. W. Robbins, of Detroit, has returned from a visit to the Mayo Clinic, in Rochester, Minn.

Dr. A. H. Eber, of St. Clair, has been given a commission as surgeon in the United States army, and left Jan. 17 for Fort Russell, near Cheyenne, Wyoming, to report for duty. Later he expects to be sent to the Philippines.

Dr. John H. Howard has moved from Byron, to 689 Campbell avenue, Detroit.

Alma Sanitarium has a new medical superintendent, Dr. R. B. Corbus, formerly a practitioner in Detroit, who succeeds Dr. Fenton Turck, of Chicago, resigned.

Dr. F. J. Schultz, of Ionia, who has been acting as interne at the State Asylum, has been promoted by Supt. Long to be an assistant physician, and Dr. W. J. Maxwell, of Toledo, is also appointed an assistant physician. This will dispense with the interne.

Dr. M. C. Sinclair, of Grand Rapids, has been appointed a member of the medical pension examining board of that city.

Dr. O. E. Chase, of Traverse City, is absent in New York.

Dr. R. C. Smith, formerly of Alpena, will locate in Spruce.

Dr. J. W. Hawkey has removed from Alanson to Hesperia, where he will take the practice of Dr. W. A. Crandall.

### Deaths

On February 5th, Dr. Charles E. Bailey died at his residence, South Jefferson street, Ionia, of diabetic gangrene. A few days before his death, he had the right leg amputated above the knee, in the vain hope to stay the destroyer. Dr. Bailey graduated from the Michigan College of Medi-

cine, at Detroit, in 1881. He practiced at Orange, in Ionia County, until three years ago, when he removed to Ionia, thinking to spend the remainder of his years in quiet comfort, as he had acquired a competence. He was a member of the Ionia County and the Michigan State Medical Societies.

Dr. James G. Conner, of Ionia, was found dead in his office, February 6th. He had been on the street but a few moments before and in usual health; but a heart trouble was responsible for his sudden death. Dr. Conner graduated in 1867 from the Rush Medical College. He spent the most of his active life as a practitioner in Ionia County and city. He held the office of city physician at the time of his death and had held the office several terms. The physicians of the city, irrespective of school, all met at the court house and passed resolutions of condolence, copies of which were forwarded to the bereaved families.

Dr. W. W. Munn, for some thirty years a practitioner in Lansing, died February 10, after long suffering.

Dr. G. W. Stone, of Metamora, died very suddenly, February 6th. For thirty years he had practiced in Lapeer County, for a number of years with his brother, Dr. D. F. Stone, now of Bay City.

Dr. Jewett Williams, Jr., of Adrian, aged 43, died on March 9th. Dr. Williams started life as a telegrapher. He graduated from the Detroit College of Medicine in 1890 and took a post-graduate course in a New York hospital. He was always interested in electrical science. He owned the first X-ray machine and the first automobile in Adrian, and to the latter can be attributed the primary cause of his death, a malignant growth on the pelvic bone, resulting from being hit by the crank of the auto. He leaves a widow and one son, Vincent, a student of the M. A. C.

Dr. H. T. Calkins, the oldest practitioner in northern Michigan, died suddenly of heart failure at his home in Petoskey, March 5. He was a Democrat and prominent in public affairs for nearly thirty years, and was active in business and social life until his health failed, a year ago. He leaves a widow and three sons.

Dr. R. H. Darling, late of Crystal Falls, died at Fond du Lac, Wis., March 2.

## Correspondence.

Port Huron, February 20, 1906.

Editor State Journal:

There is an attempt on the part of the Equitable, New York Life and Prudential Companies, all of recent unsavory notoriety, to cut down expenses in the most vital of all the work of the insurance business. Any company that thus cheapens its medical service is bound to suffer in its future increased losses.

I trust that no member of the Michigan State Society who has any respect for himself or his profession, will submit to these cheapened rates. If Paul Morton can earn \$75,000 per annum by presiding at the board meetings and looking wise, the physician who safeguards the present policy holders by excluding undesirable risks, is surely entitled to the paltry fee of five dollars.

Let us lend our influence to forwarding the interests of those substantial companies which show that they know where money is wisely spent, namely in securing the most competent medical examiners procurable and then giving them a decent fee for their services.

The following will explain itself.

Very sincerely yours,

MORTIMER WILLSON,  
Councilor for Seventh District.

### A CIRCULAR LETTER.

New York, February 15, 1906.

Dear Sir:

By order of the president, we advise you that on and after March 1st, 1906, the fees for medical examinations allowed by the Equitable Life Assurance Society, throughout the United States and Canada, will be as follows:

\$3.00 for each examination where the amount applied for is \$3,000 or less.

\$5.00 for each examination where the amount applied for is over \$3,000 and less than \$25,000.

\$7.50 for each examination where the amount applied for is \$25,000 or over and less than \$50,000.

\$10.00 for each examination where the amount applied for is \$50,000 or over.

(An extra allowance of \$1.00 will be made when an additional specimen of urine is obtained by order of the Society.)

The loading for expenses in connection with our business is a percentage of the premium, and

the uniform fee heretofore paid has made the expense of procuring a small policy too large, whereas a larger fee can properly be paid in connection with larger policies.

We do not wish to be understood as assuming that it is less work to examine a risk for \$1,000 than one for \$5,000, but the Society can properly pay more for examining a \$5,000 risk than it can for the smaller amount.

We trust that the foregoing schedule will be satisfactory to you, and will thank you to fill up, sign and return to us at once the enclosed postal.

Very truly yours,

MEDICAL DIRECTORS,  
The Equitable Life Assurance Society.

Port Huron, February 20th, 1906.

Medical Director, Equitable Life Assurance Society, New York:

Dear Sir:

Your circular letter of Feb. 15th is at hand and contents carefully noted.

I had heretofore received a similar notice from the Prudential Company, and promptly refused to do work for the company at the cheapened rates for examination.

It is well known to you that the majority of the policies will come under the cheapened rate, and only the exceptional policy will be above the old fee for examination.

I hereby decline to do any further work for your company under this new rating. You will have no difficulty in getting cheap men for cheap rates, but in the end your company will suffer for it.

Any board of directors who will cut down fees in the most important work in the insurance business, thus letting in a flood of undesirable policy holders, while it votes huge and unearned salaries to its own officers, is undeserving the support of the medical profession and the public in general.

You are therefore hereby notified of my resignation as a medical examiner of the Equitable Life.

Yours truly,  
MORTIMER WILLSON,

Cadillac, Mich., February 21, 1906.

To the Editor of the Michigan State Journal:—

I have just learned that Doctor Leeson, of this place, is making use of the names of all the physicians of Cadillac to endorse the wonderful healing power of his patent medicines, which he now has upon the market.

Not one of the physicians ever gave a written endorsement or anything equivalent to one to Dr. Leeson or to anyone else and Dr. Leeson has already been notified to discontinue the use of our names in his advertisements.

As soon as my attention was called to the matter, I sent the following letter to Dr. Leeson.

*John Leeson,*

*Cadillac, Mich.*

Sir:—My attention has just been called to a printed testimonial to which my name is appended as having been signed by me, and which testimonial is appearing in a printed circular of yours, entitled, "The Friend of Suffering Man."

You must know that I never authorized any such recommendation of you or your medicines, and that I did not sign the testimonial or any other. You are therefore hereby forbidden to further use my name in connection with this or any other testimonial of any of your compounds.

This notice to discontinue the use of my name applies to the distribution of any circulars or printed matter on hand at the present time as well as to the printing of any further circulars. I trust that you will carefully observe the requirements of this notice and thus avoid trouble in the future.

Yours truly,

(Signed) B. H. McMULLEN.

This assumption on the part of this man is something extraordinary and I am glad that our attention was called to the matter before it became a more serious one.

Yours very truly,

B. H. McMULLEN.

To the Medical Profession of the State of Michigan:

It is probably known to most of you that for several years past the Alumni Association of the Detroit College of Medicine has held public clinics and lectures covering over a period of from three to ten days preceding the day of commencement. Each year brings new faces to our meetings, and each sees the old ones return.

The coming Clinic will be held May 7th to 17th inclusive. The executive committee are striving to make this the most profitable meeting yet held. They see that while it is enjoyable and good that alumni should meet and talk over old times, renew old acquaintances and enjoy the social entertainments, yet this, after all, is not the summum bonum. Men desire something more than enjoyment, and so while the committee has not forgotten the pleasurable side of these gatherings,

yet our energy has been spent in a different direction.

We hope to make a ten-day clinic so inviting and educative that men from all over our State will see that it is for their best interest to attend. To this end we have invited some of the best men in America to come and give us a clinic on their respective branches of study. It goes without saying that we have been bountifully successful when we can offer the profession such men as Doctors Frank Billings, of Chicago, who will give a clinic on diseases of the digestive system; Bart E. McKenzie, of Toronto, Canada, a clinic on orthopedics; George Dock, of Ann Arbor, a clinic in heart disease; Howard Kelly, of Johns Hopkins University, a clinic on gynecology, and James E. Tuttle, of New York, one on diseases of the rectum. These, with our Detroit men, will give us such a feast of good things that no one can afford to stay away.

We desire your presence and you are all as welcome as our own alumni. For all this there is absolutely no charge except a registration fee of \$1.

You are most cordially invited to attend.

Very respectfully,

H. WELLINGTON YATES.

President D. C. of M. A. A.

### SURGICAL SUGGESTIONS.

For a single intravenous infusion, as to combat the shock of hemorrhage, it is not essential that the solution contain any of the blood salts but the most abundant one—sodium chloride. For repeated infusions, however, as sometimes used in treating various toxemias, it is better to employ also the other salts, the solution being made of sodium chloride 0.9, potassium chloride 0.03, calcium chloride 0.02, water 100.

Enlargement of the veins at the sides of the abdomen is indicative of obstruction to the flow of blood in the inferior vena cava; distention of veins about the umbilicus suggests obstruction in the portal circulation. The former may be associated with varices of the lower extremities, the latter with hemorrhoids.

Do not be too hasty in ascribing the cause of pain in the tendo Achilles, or Achilles bursa, to an ill-fitting shoe. First exclude gonorrheal infection.



## Progress of Medical Science

### MEDICINE.

Conducted by

H. S. OLNEY, M. D.

#### Hematuria and Albuminuria After Urotropin.

—V. KARWOWSKI reports a case of a man, 48 years old, who was given  $7\frac{1}{2}$  grains of urotropin, three times a day, on account of phosphaturia, and with good results as far as the disappearance of phosphates was concerned. But after using the drug for two weeks, suddenly severe pain was complained of, and the urine became bloody and contained 0.2% albumin. The symptoms disappeared on discontinuing the urotropin and reappeared on again giving the drug, hence there was little doubt as to its being the cause of the trouble. He has been able to collect 13 other cases in the literature, and thinks that the cause is the decomposition of urotropin into formaldehyde in the blood, instead of in the urine as normally occurs.—*Monat. f. prakt. Derm.*, Bld. XLII, No. 1.

#### Significance of Small Quantities of Sugar and Albumin in the Urine.

—BURNET is much impressed by the relative frequency of finding small amounts of albumin or sugar, or both, unexpectedly or accidentally—that is, in cases which show no other evidences of renal deficiency or of diabetes. He says that very often, by reason of strain or long continued severe mental exertion, anxiety, etc., the metabolic processes become impaired and digestion affected, and, although there are no definite signs of actual organic disease, an examination of the urine may disclose albumin or sugar, or both. This occurs most often in young males. Another class of cases which show similar conditions of the urine, are those of pronounced gouty type; the urine contains a trace of albumin and at times small amounts of sugar, easily disappearing on proper treatment, but recurring when the condition of health is poor. These persons very often live to old age, when the albumin and sugar become persistent, but not excessive, and need give rise to no especial alarm. BURNET objects to the use of the term "physiologic albuminuria," and he doubts if every any albumin escapes into the urine, without some previous impairment of the glomerular epithelium, even though this impairment may be slight and rapidly recovered from. Formerly all such cases of transient albuminuria were regarded as in-

ipient Bright's disease; then a reaction set in, and these cases were treated as of no consequence; but BURNET believes that all should receive most careful attention, especially as to work, diet and environment. Most of them do well but a certain number drift on into organic disease. He regards traces of sugar, as indicative of more serious disturbance of nutritive processes than traces of albumin, and when occurring in youth, its is of more serious import than in middle age. In the latter class of people, heavy eating and drinking are often etiological factors.

**Conclusions.**—The presence of albumin in any appreciable amount in the urine is not normal or physiologic, but does not necessarily mean that the existing disturbance of function is permanent or progressive. At the same time, it cannot be denied that a certain number of cases, which at first are rightly placed in the above category, later on show signs of definite, organic, kidney disease. (2) The presence of sugar in the urine in any appreciable quantity is abnormal; in the young, it is of serious import, and if persistent, is likely to lead to diabetes; in people past middle life, and especially in those of gouty type, it is of less consequence and usually yields to treatment more or less speedily, to recur, however, in some cases, under conditions similar to those under which it first appeared. (3) The presence of both albumin and sugar in the urine indicates serious disturbance in the metabolic processes, calling for relief, but under favorable conditions, these patients may continue, in at least fair, average, health, for many years.—*British Med. Journal*, Jan. 20, 1906.

#### Consumption of Different Kinds of Sugar in Diabetics.

—PETTITI has made an elaborate series of experiments in Senator's clinic on this subject and his conclusions are as follows: All kinds of sugar introduced into the rectum are absorbed as such. Sometimes sugar thus introduced is made better use of in the metabolism, than when given by mouth; sometimes the opposite is true; it is not known under what circumstances the one or the other applies. Whatever the kind of sugar introduced into the diabetic, either by mouth or by rectum, the secretion of sugar is always increased and the form of sugar in the urine is always dextrose. Sugar of milk seems to be best used by the diabetic, and cane sugar the worst; PETTITI thinks that sugar enemata, especially of sugar of milk, could be considered in the diabetic diet.—*Berliner klin. Wochenschrift*, 5 Feby., 1906.

## SURGERY.

Conducted by

MAX BALLIN, M. D.

**Amputations Below the Knee.**—CLAPP made inquiries from one hundred surgeons and thirty-five limb-makers about their experience as to the value of the different methods of amputating the foot and leg and the ultimate usefulness of the stump was especially considered. The conclusions from these inquiries are: An ideal leg amputation seems to be superior to many Chopart, Symes and most Pirogoff amputations. The Lisfranc gives a very satisfactory stump. In amputation of the leg, be certain of sufficient flap to properly cover the end of bone, regardless of how close this may come to the knee joint. Flap must be considered first, length of stump second. The most uniformly good results are obtained by making the long anterior with short posterior flap, bringing the scar well away from end of stump. Redundancy is always undesirable. When the length of the stump is at the discretion of the operator, it should be from 6 to 9 inches below the lower border of the patella. Periosteal flap with coaptation of muscles over the end of bone is always desirable. Always cut the fibula one inch shorter than the tibia, and when the amputation is near the knee-joint, disarticulate the fibula. In all these amputations nerves should be cut as short as possible.—*Journal American Medical Association*, February 10, 1906.

**Stomach as Contents of Right Diaphragmatic Hernia, With Secondary Protrusion Into Abdominal Cavity, Diagnosed as Right Sided Pyonephrosis. An Anatomical Curiosity.**—A Turk, 50 years old, was operated on for stone in the bladder. He also showed a tumor in the right lumbar region, that seemed to fluctuate and disappear sometimes, without causing any change of urine, but still was considered a pyohydronephrosis. Patient died soon after the operation.

The autopsy showed that the major part of the stomach was situated in a diaphragmatic hernia sac. The same protruded both into the pleural and abdominal cavity. The hernia ring was situated in front of the inferior vena cava. It was the abdominal part of the hernia that had imposed as the fluctuating tumor. The stomach was adherent to the hernial sac and showed several round ulcers, and as contents, a large white crystallized stone. This stone was proved to consist of salol which the patient had taken for a cystitis and which had remained in the hernia pouch of the stomach. There was no record of traumatic origin of the hernia.—Hamdi: *Deutsche Zeitschrift f. Chirurgie*, Vol. 79, p. 313.

**Enucleation of the Prostate for Hemorrhage.**

—A man, 57 years old, had repeated severe hemorrhages from the bladder. There were no signs of stone in the kidney, no colics, no shadow of stone in skiagraphs. Neither could any stones be felt in the bladder. The only positive symptoms were a very large prostate and the profuse hemorrhage. There were also no other symptoms from the large prostate, no retention of urine, no frequency of micturition. The blood came away in large quantities and was bright. Suprapubic prostatectomy was performed and 32 small stones were found in a post-prostatic pouch. The left lobe of the removed prostate showed three patches of extravasation, no doubt the cause of the hemorrhage. Patient made an uneventful recovery, no further bleeding occurred. SIR THOMPSON considers this the first case, where the removal of the prostate has been advocated or deliberately practised for alarming hemorrhage.—*British Medical Journal*, Jan. 27, 1906.

**Scopolamine—Morphine—Ethyl Chloride—**

**Ether Anaesthesia.**—ROYSTER applies this method in the following way: At intervals, varying from a half hour to two hours before the time set for operation, (one hour has been the average time), there is given a hypodermic injection of morphine one-sixth grain and scopolamine 1-100 grain. When the patient is brought in, the ethyl chloride is first administered by spraying it on gauze folded in several layers over the nose and mouth. This requires, as a rule, one minute to produce a primary anaesthesia. When this stage is complete, the cone saturated with ether is placed over the face, and in four or five minutes more the patient is ready. A few deaths have followed the use of scopolamine—even a single dose—and whether or not attributable to scopolamine, this is enough to make us feel that it is not harmless. Moreover, the appearance of the patients under its influence associated with morphia has been such as to suggest alarming thoughts.—*Surgery, Gynecology and Obstetrics*, February, 1906.

## GYNECOLOGY AND OBSTETRICS.

Conducted by

REUBEN PETERSON, M. D.

**Hysterectomy for Fibroids of the Uterus.—**

DEAVER, reporting upon 250 operations for fibroids of the uterus, concludes as follows:

Fibroids of the uterus do not require removal unless they are productive of symptoms; but when they do become symptom-productive they should be removed promptly, before the patient has been weakened by toxemia, hemorrhage or sepsis.

Abdominal supravaginal hysterectomy is the operation to be preferred in the vast majority of cases.

Myomectomy is applicable only to younger women, in whom the tumors are few in number and subperitoneal in character.

Pan-hysterectomy is to be employed only when intraligamentary growths, whether uterine or ovarian, render the performance of supravaginal amputation difficult or dangerous.

The ovaries or a part of one ovary should be preserved in every woman who has not reached the age of the menopause, unless they are distinctly and indisputably diseased, or unless their retention would needlessly prolong and complicate the operation.

DEAVER makes it a rule to drain when there is oozing, in pelvic operations, which cannot be controlled by catgut sutures, which do not entail risk to the ureters. Even a small clot while sterile at the onset, does not necessarily remain so; while, if proper drainage is used, the risk is certainly minimized, if not removed altogether. In supravaginal hysterectomy he uses large clamps on the broad ligaments, cuts and then ties, thus making a short operation. In the complete abdominal operation, when the uterus is large, and the pelvis deep, making it difficult to reach the uterine arteries, he makes a supravaginal amputation, then grasps the cervix with the Volcella forceps, and cuts it out of the vagina with a pair of scissors, thus making a very rapid operation. In the vaginal operation he invariably uses Pryor's vaginal clamps.—*American Jour. of Obstet.*, Dec., 1905.

**Myomectomy and Ovariectomy During Labor**—DORAN reports two abdominal operations for the removal of tumors during pregnancy without interruption of that process. In the first case an adherent, subserous fibromyoma was removed by myomectomy from a patient two months pregnant. The patient was delivered at term after a lingering labor of 36 hours, due to hydramnios.

Thumim tabulates 62 cases of simple myo-

mectomy in pregnancy, performed between 1885 and 1900, with six deaths, two from sepsis, both infected before operation; one from peritonitis; also existant before the removal of the tumor; two from "heart failure," and one from hemorrhage of the stump. Only ten patients aborted. Enucleation is easier during pregnancy, because the hyperplasia of the connective tissue favors the manual separation of the tumor from the uterine walls.

In the second case, a solid fibroma of the ovary weighing 11 ozs. was removed from a woman three months pregnant. The tumor was attached to the right appendages by a very narrow pedicle. The patient went to full term, and was delivered of a normal, healthy child.

Ovariectomy during pregnancy is attended with very little danger to the life of the mother, and not much to the fetus. In 486 ovariectomies during pregnancy collected by McKerron there were 451 recoveries. McKerron demonstrates that the mortality due to the operation for the removal of the ovarian tumor may be reduced to nine in this series. In 289 cases there were 54 interruptions of the pregnancies with loss of the children. Very bad results may follow postponement of the operation until after labor.

Fibroma of the ovary resembles in many respects a pedunculated subserous uterine fibroid. It is more dangerous during pregnancy than the latter, which is more apt to rise up out of the pelvis as the pregnant uterus increases in size. Fibroma of the ovary is more frequent in young women and, for the reasons stated above, pelvic impaction is not uncommon.

According to Coudert, in a recent monograph on solid pelvic and abdominal tumors of the ovary associated with pregnancy, it is advisable to operate as soon as the diagnosis is established no matter what may be the nature of the tumor. This is because the removal of a fibroid of the ovary during pregnancy is usually an easy task, involving little damage to mother or child, while it is quite otherwise with any kind of operation during labor. The endeavor to push up a pelvic tumor during labor is, according to Bland-Sutton, in opposition to all the canons of surgery. The dangers of bursting a dermoid full of grease and hair are evident—half measures in cases of pelvic tumors complicating pregnancy, are deadly, while bold surgery has proved itself triumphant.—*Journal of Obstetrics and Gynecology*, November, 1905.

## PATHOLOGY AND BACTERIOLOGY

Conducted by

A. P. OHLMACHER, M. D.

**Cirrhosis of the Pancreas in Diabetes.**—Amplifying his previous reports, HERXHEIMER now communicates the results of a very thorough study of the pancreas in five additional cases of diabetes coming directly under his personal observation. A striking uniformity characterized the pancreatic lesions in these cases which consisted of a pronounced atrophy of the parenchyma, both the individual cellular elements and the glandular acini, accompanied by a proliferation of the connective tissue, varying in amount and distribution. In all these cases, Langerhan's islets were very numerous and prominent; most of them were of the ordinary size, though occasional colossal cell groups were found, apparently produced by the confluence of several newly formed islets. The majority of these islets were normal, though many closely invested with connective tissue, were sclerotic. Hyaline degeneration of Langerhan's cell groups could be detected in each of the five cases, always involving but a portion of the islet, very irregular in its distribution, not affecting the component cells, but confined to the capillaries and the connective tissue. Hyaline metamorphosis of the smaller blood vessels of the parenchyma was noted in each pancreas. HERXHEIMER maintains that in all these cases he could satisfy himself as to the origin of Langerhan's islets from the parenchymatous acini, the stages of the process being readily traced. According to his view, a degenerative process in the parenchyma of the pancreas with pronounced connective tissue proliferation and various evidences of regeneration, that is, a true cirrhosis, constitutes the morbid histology of pancreatic diabetes. He dissents entirely from the theory which ascribes to a destruction of Langerhan's islets, a prominent part in the causation of diabetes, and the hypothesis of vicarious hypertrophy of these cell groups in non-diabetic affections of the pancreas also meets his disapproval.—*Virchow's Archiv*, 1906, Bd. 183, Heft 2, pp. 228-341.

**The Adrenals in Tuberculosis.**—From 30 autopsies in cases of tuberculosis, taken at random, BERNARD and BIZART studied the suprarenal glands. Most of the cases were of phthisis, others of acute general tuberculosis and of tuberculosis localized in the pleura, liver or kidneys. Lesions such as adenoma, amyloid degeneration, hemorrhage or true tubercle of the adrenals were excluded from the study which concerned itself with a characteristic alteration of the organ manifested by increased consistency, and shown by

histologic study to be a sclerosis, most evident in the cortex but also invading the medulla. Instantly associated with this sclerosis was a lymphocytosis, and it was accompanied with an atrophy of the cells and tubules composing the adrenal parenchyma. Compensatory process was signaled by the presence of zones of regenerating adrenal tubules and by hyperplastic parenchymatous nodules in the cortex. What part this form of sclerosis had in producing the occasional slight melanoderma, as compared with the more pronounced lesions (tubercle, amyloid, adenoma and hemorrhage), could not be settled. *Jour. de Physiologie et de Pathologie générale*, 1906, T. VIII, No. 1, pp. 84-92.

**The Influence of a Serum Specific for Trypanosoma Brucei Upon the Trypanosome of Sleeping Sickness.**—KLEINE and MÖLLERS conducted experiments to determine the specificity of serum from animals rendered immune to trypanosome infection. The present report concerns the effect of a serum described by Koch and obtained by administering to an ass, periodical intravenous injections of white rat's blood, at the stage of maximum infection with *Trypanosoma brucei* (the parasite of nagana or tsetse-fly disease). Its protective and curative properties for nagana infection were conclusively demonstrated by experiments on mice. The same serum was, however, ineffective in controlling the usual progress of the disease induced in mice inoculated with blood containing *T. gambiense* (the trypanosome of Sleeping Sickness), thus additionally demonstrating the distinctive variation of the two species of pathogenic flagellates, and the selective affinity of the serum of nagana.—*Zeit. f. Hygiene*, 1906, Bd. 52, Heft 2, pp. 229-237.

**The Effect of Brilliant Green Upon the Nagana Trypanosome.**—Following their previous communication on the use of malachite green in experimental tsetse-fly disease, MENDELSTADT and FELLNER give the results following a trial of the anilin, brilliant green. The use of anilins to combat experimental trypanosomiasis is not new, the procedure having been tried by Ehrlich and Shiga leading to the recommendation of "Trypan-rot." Aqueous brilliant green (1 to 200) in subcutaneous injection effectually eliminated normal trypanosomes in 24 to 30 hours from white rats whose blood was teeming with trypanosomes. Subsequent tests of the blood of such treated animals showed it to be non-infectious. The same result was obtained in a monkey. Combined with arsenic administration, the effect of the anilin was heightened. A cyst-like "resisting stage" (?) of the trypanosomes was found after treatment with brilliant green, and the conjecture is advanced that this body represents a form which harbors in the spleen pending its future development.—*Zeit. f. Hygiene*, 1906, Bd. 52, Heft. 2, pp. 263-281.



## PHARMACOLOGY AND THERAPEUTICS.

Conducted by

C. W. EDMUNDS, M. D.

**Coagulation Time of the Blood.**—WRIGHT and PARAMORE report their results from the use of several agents to alter the coagulation time of the blood. Calcium chloride, given in 60 grain doses, produced its maximum effect in about one hour, when the time required for coagulation was from one-third to one-half as long as normal. In one case, the time was reduced from two minutes and ten seconds to thirty-five seconds; in another instance, from two minutes and fifteen seconds to forty-five seconds. This increase in the coagulability lasted, in some cases, for eight days, the period of time over which observations were made. Calcium lactate, also given in 60 grain doses, gave similar results, excepting that the effects were manifest earlier than with the chloride, sometimes in twenty minutes, and the maximum was attained in three-quarters of an hour. In one case, when the last observation was made, seventeen days after the administration of the drug, the increased coagulability was still present.

Magnesium carbonate exhibited in like doses produced the same effects.

Cow's milk, probably from its content of calcium and magnesium salts also lessens the coagulation time of the blood. For this purpose about one and a half pints daily are sufficient. This action of milk the authors think may predispose to thrombosis, in cases of typhoid fever which are fed on a diet consisting largely of this food.

In rare cases, calcium salts seem to have no effect when given by the mouth, probably because, for some reason, they are not absorbed. In such instances, the effect may sometimes be produced by administering the salts by hypodermic, and for this purpose the lactate should be used, in 1 to 20 dilution, as the lactate is more soluble than the chloride and less irritating. Citric acid lessens the coagulability of the blood. In one case the time was increased from one minute to two and a half. The authors found this condition

persisted for about a month and then, in spite of the continued use of the drug, the coagulability gradually returned to the normal.—*Lancet*, Oct. 14, 1905.

**Digitalis in Cardiac Failure.**—BRUCE, in a clinical lecture on the action and uses of digitalis in cardiac failure, makes the following points as to the use of this drug. Where it is given in the ordinary doses of the pharmacopoeal preparations, diuresis does not appear before the third or fourth day of administration. If the drug then fails to produce diuresis, it is because it is not given in large enough doses and instead of being discontinued it should be given in larger amounts. The small irregular pulse, met with in cases of cardiac failure under treatment with digitalis, is not an effect of an excessive but of an insufficient dose. After the diuretic action is obtained, the drug must not be suddenly withdrawn but the dose must be slowly reduced before its final removal, continuing it for some time after the disappearance of the dropsy.

The changes in the characters of the pulse, especially as regards frequency, in response to digitalis, precede the appearance of diuresis and persist after its disappearance. BRUCE does not regard aortic insufficiency as any contra-indication to the use of the drug.

He does not consider that such preparations as Nativelle's crystallized digitalin, digitoxin, etc., possess any great advantage over the pharmacopoeal preparations, in as far as the time of appearance of diuresis is concerned, but strophanthin seems to act more quickly and might be employed where a rapid effect is desired.

He closes his address with the advice, to "Measure the urine." It is an accurate and sufficient index of the patient's progress, a test which is very easily and rapidly carried out and about which there can be no mistake. Differences of opinion may arise in regard to the changes in the pulse and heart sounds, but volume of urine can be absolutely determined.—*British Medical Journal*, Jan. 6, 1906.

## PEDIATRICS.

Conducted by

R. S. ROWLAND, M. D.

**Pleural Effusions, Serous and Purulent, in Children.**—At a special meeting of the British Society for the Study of Disease in Children, J. G. EMANUEL remarked that serous effusions are four times as common as purulent in adults, but in children, they occur in about equal numbers. In adults, a purulent effusion is often secondary to serous, but in children, it is generally purulent from the first. Seventy-five per cent of empyemata in children are pneumococcal and these may be either secondary to pneumonia or primary. Streptococcal empyema is rare in children, but common in adults. Epyemata containing staphylococci, often indicate tuberculosis.

Speaking in regard to the quantity of fluid, DR. CARPENTER said that it is variable. In simple effusion, 46 ounces, in a child of six, was the most he had removed. Of pus, the average, in his experience is 8 to 10 ounces, caught at the time of operation but a large amount drained away subsequently.

DR. SUTHERLAND referred to the frequent absence and slight character of the symptoms in many cases of moderate effusion. A diagnosis can only be made by careful examination of the chest, noting the position and condition of the lungs, heart and diaphragm, as indicated by stomach resonance, and the hepatic dullness. The chief use of the exploring needle is not to determine the presence of fluid, but to distinguish between serous and purulent effusion.

DR. CARPENTER, in describing various clinical types, mentions a common form, with signs of consolidation of the upper and middle lobes and deficient, very rarely absent, vesicular breathing over the lower lobe. In another type, the chest may be full from apex to base with good, but distant, vesicular breath sounds or distant tubular breathing, perhaps heard only on deep breathing. With this extreme effusion, there may be a typical resonance, the breathing clear and distinct, expiration prolonged and unduly audible, compared with inspiration. In another type, there is dullness over the lower lobe and deficient entry of air. Sometimes the breath sounds are distant tubular. In either case, there may be loud tubular breathing at the upper limit of dullness, with friction sounds or not, sometimes with pneumonic crackles only. Skodaic resonance can frequently be obtained, in front, over the corresponding apex, above the clavicle, below it in some situations,

and sometimes behind. On the healthy side, the breath sounds are extra-*puerile*. Percussion gives fluid dullness and fluid resistance, but both may be encountered over a solid lung. Because the dullness is not of fluid character, it does not follow that fluid is not present. Bronchophony contraindicates fluid.

Exploration is alone reliable in determining whether an effusion is purulent or not. No danger need be apprehended from passing an exploring needle into a pleura full of fluid, but it is dangerous to pass a needle into a cirrhotic lung, and it may be dangerous to wound a pneumotric lung.

CARPENTER strongly advises free incision, and usually resection of one or two ribs, in purulent effusions. While admitting that some empyemata may recover by aspiration, only repeated once or more, he did not think that there are any advantages attached to the method and there are many disadvantages. With simple effusion, if the pleural cavity is full, aspiration should be performed at once for fear of sudden death. Simple fluid should not be left in the chest longer than three weeks lest the lung contract adhesions. If there be fever, the fluid should not be aspirated, lest there be reaccumulation. Aspiration should cease as soon as the child commences to cough.

DR. HOBHOUSE said there could be no doubt that it is possible to cut short the acute pleurisy and prevent effusion by active measures in the early stage, but when once effusion has fairly commenced, it is very doubtful whether it can be cut short by medical measures. Two different lines of treatment have been pursued by different authorities. In the first instance, it was sought to reduce the quantity of fluid by increasing the fluid output and reducing the intake. With this object, diuretics, diaphoretics, and purgatives were freely given and a thirst diet adopted; most authorities are agreed that the results obtained are by no means proportionate to the discomfort entailed. If a reasonable trial of medical measures is insufficient to reduce the effusion, it will be necessary to remove the fluid by puncture.—*The British Journal of Children's Diseases*, January, 1906, p. 25.

## DERMATOLOGY AND SYPHILIS.

Conducted by

A. P. BIDDLE, M. D.

**Hereditary Syphilis.**—TAYLOR attempts to prove, by cases, that third infection in syphilis is an established fact. A synopsis of the first case is as follows: First—Grandmother infected with syphilis in 1869, had secondary and tertiary lesions of much severity. She was careless of treatment. She was the first genitor. Second—In 1872 this woman gave birth to a girl baby which presented classical hereditary syphilitic symptoms. After many vicissitudes this child (the second genitor) grew up seemingly healthy and strong, and never having been infected with acquired syphilis, she in two years gave birth to a baby daughter. Third.—In 1890 this second genitor gave birth to a miserable weakling girl, atrophic, marasmic, with very little strength and vitality, who at birth gave no distinct evidence of hereditary syphilis (third generation), but who in five years developed true dystrophic symptoms; Hutchinson's teeth, keratitis, ear troubles, and osseous swellings, and later showed unmistakable evidence of a virulent form of late syphilitic infection (third) in characteristic gummatous tumors and ulcers. This third syphilitic by inheritance is now growing up a victim of infantilism and general atrophy. A synopsis of the second case is as follows: First.—A healthy woman, married to a man, syphilitic two years, contracted syphilis two years later coincidently with the development of pregnancy. Second.—She gave birth to a male child who, soon after birth, was characteristically heredito-syphilitic and later developed typical undoubted evidences of inherited taint, which showed themselves for several years. He never was infected with acquired syphilis. He married a healthy girl. Third.—Three years after the marriage of this second genitor, the wife gave birth to a thin, weakly girl, who presented the appearances of infantilism. At 4 years many dystrophic symptoms of the bones and joints developed and were promptly cured by active anti-syphilitic treatment. This case, therefore, was a clearly marked illustration of the development of syphilis in three generations. In the first, active syphilis; in the second, virulent hereditary syphilis; and, in the third, a dyscrasic condition attended with well-marked dystrophic changes.—*New York Medical Journal*, Feb. 3, 1906.

**The Etiology of Eczema.**—McGUIRE does not believe that gout, rheumatism, and many other of the diseases referred to as factors predisposing

to eczema, have anything whatever to do, either with causing the disease, or in influencing it in any way after it has been established, only so far as any "run-down condition" of the general system makes the cuticle less resistant to irritation. As to heredity, although no child was ever born with eczema, many have a vulnerable skin, and may later develop the disease under favorable circumstances. The consensus of opinion holds that the disease is neither contagious nor auto-inoculable. However, the parasitic theory is growing, even in the minds of those who formerly opposed it. It cannot be denied that some individuals have an idiosyncrasy, a susceptibility of the cuticle to develop different forms of inflammation, varying according to the nature of the irritant. Want of cleanliness alone will not cause any form of inflammation upon a normal skin. As a rule, water is poisonous to an eczematous skin and should be avoided as much as possible during a period of acute inflammation. Soap makes the cuticle more sensitive, by thinning the outer layer and depriving it of its natural oiliness. The writer declares that in his opinion, some time in the near future the term eczema will be limited to that form of cutaneous disease that is caused by some specific parasite acting upon a vulnerable skin. He then cites a case, the only one which he can recall in which the tendency to the disease appeared to be distinctly transmitted to the offspring. Two cases of so-called "reflex eczema" are then described. In one of these cases the prepuce was very long and the writer advised circumcision. The child was entirely relieved soon after the operation had been performed. The history of several patients suffering from typical neurotic eczema is given. McGUIRE finds that in private practice children under the age of six, affected with eczema are particularly robust, strong, and healthy. Improper food in the majority of these cases is the only cause of this disease which he has been able to find. In public practice these patients are usually weak, anemic and "strumous." The reason for this difference between the two classes does not seem to be known.—*Medical Record*, Feb. 24, 1906.

## ORTHOPEDIC SURGERY.

Conducted by

WILLIAM E. BLODGETT, M. D.

**Decollement de l'Epiphyse Inferieure du Radius. Etat du Radius Vingt Ans Apres.**—A boy of nine fell, and was believed to have fractured the lower end of his right radius. Twenty years later, radiographs showed that the epiphysis had been separated. The right radius was 7 c. m. shorter than the left, and showed trophic changes. On the anterior surface of the radius at the carpal end was an exostosis of considerable size. The lower end of the ulna was half way down the side of the carpus, opposite the cuboid, which was turned so that its long axis was parallel with the axis of the arm. Three excellent radiographs are appended—(Walter, *Revue d'Orthopédie*, Sept., 1905, VI., 5 p. 385.)

**Hanche a Ressort. Ressaut Fessler-trochanterien.**—Case reported in which flexion or extension of the right thigh produced an audible and palpable snap over the great trochanter. Examination was entirely negative. Exploratory incision failed to show anything abnormal, such as bursitis, or undue extension or thickening of the trochanter or anterior border of the gluteus maximus. It was seen that the snap was made by the slipping of the trochanter under, and out from under, the gluteus maximus, and elevation of the anterior border of the muscle was found to prevent the snap. It is suggested that this functional anomaly may have arisen from the patient's manifest effort to simulate disease, although attempts to reproduce the condition in other individuals, both by voluntary efforts and with the aid of faradic stimulation of the anterior part of the gluteus maximus, were failures.—(Ferreton, *Revue d'Orthopédie*, Jan., 1905, VI., 1, p. 45.)

**The Study of the Clinical Course of Joint Tuberculosis by Means of the X-Rays.**—This article is a series of case-reports and excellent radiographs to support the author's proposition that the X-rays are of indispensable usefulness not only in the initial diagnosis but also in the progress of the joint disease as a guide to treatment, because the kind and duration of treatment of joint tuberculosis should depend upon the course of the disease in the individual case, and because accurate and frequent radiography furnishes trustworthy evidence that will verify, or often anticipate and correct clinical indications. The orthopedist, therefore, should have at constant command this means of joint examination. Loss of distinctness of articular bone-contour, and bone atrophy often at a distance from the joint, are especially referred to as marking radiographically the progress of joint tuberculosis.—(Albert H. Freiberg, *International Clinic*, IV., Fifteenth Series, 1906, p. 139.)

**Achillotomy and Fasciotomy in a Patient Seventy-two Years Old.**—The tendo Achillis was divided under local anaesthesia for the relief

of a mild degree of club-foot that had resulted from infantile paralysis and had caused an ulcerating callus on the outer side of the front of the sole. The foot was held in over correction by plaster of paris bandage for three weeks, during which time the patient walked with crutches and bore his weight on both feet as usual. Then the foot was strapped with adhesive plaster, as for a sprained ankle. Within a week after removal of the plaster, the patient was walking very well without crutches, and, with the aid of an ointment of 15 grains salicylic acid to the ounce of zinc oxide ointment, the callus had entirely disappeared. The case is reported to show that old age, unless diseased beyond the usual, does not contra-indicate tenotomies or other such proceedings, and does not retard repair. This was further brought out in the discussion by reference to a patient seventy-five years old whose hamstrings had been tenotomized for contracture of the knee so severe that the heel touched the buttock. The result was good.—(A. R. Shands, *American Jour. Orthopedic Surg.*, Oct. 1905, III., 2, p. 175.)

**More Rapid Correction of Lateral Curvature of the Spine.**—For cases of scoliosis in which structural changes are present, i. e., cases that cannot at first be actively or passively nearly straightened, the author advocates application of successive plaster jackets with the patient lying on a "hammock" within a gaspipe frame. The shoulders are held back by two webbing straps running the length of the frame, traction is applied to feet and head, and strong corrective lateral pull is exerted on the summits of the convexities of the dorsal and lumbar curves. (Corrective force may be applied also to the rotary deformity by a weight attached to one side of the frame and allowed to hang down over the backward rotation, usually the right mid-dorsal region.) From four to eight of these jackets are applied, one every three or four weeks, with increasing degrees of correction. At the end of the series, the spine is much more straightenable passively, but the muscles require training and strengthening in order to maintain the straightened position. During this muscle training, a removable, retentive apparatus is required, as, for instance, a stiff leather jacket. The particular point in the article is the use of shoulder straps incorporated in the plaster jackets to hold the shoulders back, so that the part of the jacket over the upper front chest can be cut out, thus allowing free thoracic respiration, an important consideration in a series of unremovable jackets, both for the spinal deformity and for the general health of these scoliotics, who not infrequently lack vigor.—Walter Truslow, *Brooklyn Med. Jour.*, Dec. 1905, XIX., 12, p. 445.)